Army Regulation 600–110

Personnel—General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)

Headquarters
Department of the Army
Washington, DC
1 June 1996

UNCLASSIFIED

SUMMARY of CHANGE

AR 600–110
Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)

This Change 1--

- Implements provisions regarding Army National Guard (ARNG) and U.S. Army Reserve (USAR) surveillance testing for HIV infection.

- The testing frequency requirement for ARNG and USAR has been changed from every 2 years to every 5 years because of limited training opportunities and increasing budget constraints.

- This revision--

- Reorganizes the regulation to add two new chapters: Chapter 6 now contains all policies and procedures pertaining to civilian health care beneficiaries and civilian employees. Chapter 9 provides policies and procedures for law enforcement and corrections personnel.

- Redesignates chapter 6 as chapter 7.

- Replaces the old chapter 7, Public Affairs Plan, with a new chapter 8, HIV Information and Education Plan.

- Changes technical terminology to reflect current usage.

- Expands OTSG’s responsibilities in the HIV testing and education program (paras 1-5, 8-3, and 8-6).

- Expands commanders’ responsibilities to include educating civilian employees (para 8-5).

- Clarifies the standards for determining the deployability of soldiers (para 1-14).

- Provides guidance for testing soldiers under mobilization conditions (para 1-14).

- Adds specific guidance for managing HIV- infected civilian employees (paras 6-15 and 6-16).

- Incorporates the provisions of Interim Change I01 pertaining to HIV-infected RC soldiers and the notification, testing, and counseling requirements for their spouses (paras 5-8, 5-10, 5-15, and 5-17).

- Updates information on the HIV test date data element on SIDPERS (para 2-7).

- Incorporates a new requirement for mandatory testing of civilian employees under specific conditions (para 6-15).

- Clarifies the validity period of a pre- accession/pre-appointment HIV test (para 3-3).

- Changes the assignment of AEA codes for HIV- infected enlisted soldiers (para 4-7).

- Adds guidance to commanders regarding proper utilization of HIV-infected soldiers (para 4-6).

- Changes assignment policy for HIV-infected soldiers (para 4-2).

- Changes the policy which previously precluded HIV-infected soldiers from reclassifying or retraining into new skills (para 4-4).

- Change 1 dated 1 June 1996 has been incorporated into the text.

Headquarters
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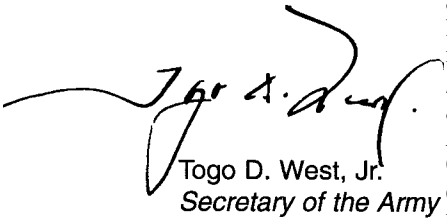
Washington, DC
1 June 1996

*Army Regulation 600–110

Effective 1 July 1996

Personnel—General

Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus (HIV)



Togo D. West, Jr.
Secretary of the Army

History. This publication was originally published on 22 April 1994. Change 1, dated 1 June 1996, effective 1 July 1996, has been incorporated into the basic publication. No highlighting was used to indicate change data. This printing publishes change 1.

Summary. This regulation implements DOD Directive 6485.1 and prescribes Army policy and responsibilities on Human Immunodeficiency Virus (HIV) testing and surveillance requirements; procedures for identification, surveillance, and administration of personnel infected with HIV; testing and counseling procedures for soldiers and other military health care beneficiaries for HIV infection; requirements for testing military applicants; conditions under which civilian employees may be tested; procedures for administration of HIV infected active duty, Army National Guard, and U.S. Army Reserve soldiers; guidance on the limitations on the use of testing information; establishes information and education requirements of the HIV testing program; and provides guidance to law enforcement and corrections personnel in handling known or suspected HIV-infected personnel.

Applicability. This regulation applies to all soldiers of the Active Army (including Active Guard/Reserve), Army National Guard, and the U.S. Army Reserve; candidates and applicants for accession; Department of the Army civilian employees; nonappropriated fund employees; and military health care beneficiaries. If the provisions of this regulation conflict with existing negotiated labor agreements, the terms of those agreements will be controlling until renegotiated. In any activity where a union has been granted exclusive recognition to represent civilian employees, no new conditions of employment should be implemented without prior discussion with the servicing civilian personnel officer regarding the obligation to negotiate.

Proponent and exception authority. The proponent of this regulation is the Deputy Chief of Staff for Personnel (DCSPER). The DCSPER has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

Army management control process. This regulation is not subject to the requirements of AR 11-2. It does not contain internal control provisions.

Supplementation. Supplementation of this regulation and establishment of local and command forms are prohibited without prior approval from HQDA (DAPE-HR-PR), WASH DC 20310–0300.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to ATTN DAPE–HR–PR, DEPUTY CHIEF OF STAFF FOR PERSONNEL, 300 ARMY PENTAGON, WASHINGTON DC 20310–0300.

Distribution. Distribution of this publication is made in accordance with Initial Distribution Number (IDN) 093902, intended for command levels A, B, C, D, and E for Active Army, Army National Guard, and the U.S. Army Reserve.

Contents (Listed by paragraph and page number)

*This regulation supersedes AR 600-110, 11 March 1988.

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Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation prescribes policy, procedures, responsibilities, and standards concerning identification, surveillance, and administration of personnel infected with Human Immunodeficiency Virus (HIV).

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

Section II
Responsibilities

1–4. Deputy Chief of Staff for Personnel (DCSPER)
The DCSPER will—

a. Serve as executive agent for all HIV policies.

b. Provide Army Staff supervision for the HIV program.

c. Coordinate with U.S. Military Entrance Processing Command (USMEPCOM) policies pertaining to preaccession HIV antibody testing conducted at Military Entrance Processing Stations (MEPS).

d. Ensure that HIV policies and programs are effectively implemented consistent with Department of Defense (DOD) guidance and current medical knowledge.

1–5. The Surgeon General (TSG)
TSG will—

a. Program and manage funds and resources for the support of laboratory, research, education, and contractor activities for medical aspects of the overall HIV program.

b. Provide up-to-date clinical and epidemiological information to the Army Staff and Secretariat on HIV and Acquired Immune Deficiency Syndrome (AIDS).

c. Ensure responsive laboratory support to the active Army and Reserve Components (RC), and to other testing programs for authorized health care beneficiaries (HCBs).

d. Manage the professional medical and epidemiological aspects of the HIV program.

e. Advise the Office of the DCSPER (ODCSPER) and the Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs) (OASA(M&RA)) of Department of the Army (DA) and DOD epidemiological information and trends.

f. Develop programs for health education and preventive medicine counseling of all HCB, especially those who are HIV-infected, or at high risk.

g. Develop health education materials for use in the military community.

h. Assist major Army commands (MACOMs) in the development and implementation of community health education programs regarding HIV infection and AIDS.

i. Develop procedures for notification of HIV-infected HCBs.

j. Provide input concerning the medical administration of the HIV testing program for publication in this regulation.

k. Provide technical oversight in support of the Army's HIV testing program, to include guidance on the most current and appropriate laboratory tests to be used for screening and confirmation.

l. Prescribe the methodology to be used by the laboratories supporting HIV testing.

m. Provide technical guidance for the collection and shipment of specimens.

n. Plan, program, and manage research initiatives through the U.S. Army Medical Research and Development Command (USAMRDC). Centralization of research initiatives allows for better utilization and protection of the test pool. Permission to conduct HIV studies is coordinated through the Assistant Surgeon General for Research and Development. The focus of the research effort will be on the development of vaccines, chemoprophylaxis, epidemiological and behavioral studies.

1–6. Chief of Chaplains (CCH)

The CCH will provide pastoral care by ensuring that chaplain counseling and religious support is available to soldiers and family members who are infected with HIV and the uninfected members of those families.

1–7. Chief of Public Affairs (CPA)

The CPA will, in coordination with the Office of TSG (OTSG) and ODCSPER public affairs officers (PAO), support a command information program that informs audiences about current information pertaining to HIV infection and the AIDS epidemic. The CPA will also help publicize the Army's testing, research, and education efforts related to HIV and AIDS.

1–8. Chief, National Guard Bureau (CNGB)

The CNGB will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in the Army National Guard (ARNG).

b. Provide and coordinate medical support for the notification and counseling of HIV-infected ARNG soldiers and their spouses.

c. Ensure ARNG units comply with the Army's HIV policy.

d. Advise ODCSPER regarding the impact of HIV programs on ARNG personnel and units.

1–9. Chief, Army Reserve (CAR)

The CAR will—

a. Submit to Forces Command money and other resource requirements to provide administrative support for oversight of the HIV testing program in the U.S. Army Reserve (USAR).

b. Provide and coordinate medical support for the notification and counseling of HIV-infected USAR soldiers and their spouses.

c. Develop and coordinate USAR HIV policy for specified and unified commands, MACOMs, and the U.S. Army Reserve Personnel Center (ARPERCEN).

d. Advise ODCSPER regarding the impact of HIV programs on USAR personnel and units.

1–10. Commanders of Health Services Command, 7th Medical Command, and 18th Medical Command

These commanders will—

a. Identify appropriate resources and locations to collect and ship specimens to the servicing laboratories.

b. Ensure that information regarding HIV test results is appropriately safeguarded according to the policies in this regulation.

c. Coordinate testing, notification, counseling, and education procedures with OTSG. Provide medical support for these functions per guidance from OTSG.

d. Ensure that epidemiologic assessment interviews and counseling are performed and that all medical requirements are accomplished according to the policies in this regulation, or request exceptions to policy when appropriate.

e. Ensure that guidance published by OTSG regarding the Blood Donor and Transfusion Recipient Look Back Program is followed within their command.

1–11. MACOM commanders

MACOM commanders will—

a. Budget money and resources to provide administrative support for oversight of the HIV testing program in their command.

b. Designate a centralized point of contact (POC) in their headquarters to coordinate all administrative, educational, and medical aspects of the HIV testing program.

c. Ensure compliance with all aspects of the HIV testing program outlined in this regulation at their various installations and activities.

d. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

e. Ensure that their PAO conducts an aggressive command information program per chapter 8.

1–12. Installation and community commanders

These commanders will—

a. Coordinate with the servicing medical department activity (MEDDAC) or medical center (MEDCEN) to accomplish scheduling, education, and testing of personnel assigned to their installation/community.

b. Assist servicing MEDDAC or MEDCEN in developing and implementing well-defined health education programs for soldiers, family members, civilian employees, and other HCBs in the community.

c. Establish a support network of professional personnel (chaplain, psychologist, psychiatrist, social worker, community health nurse) trained to provide assistance to HIV-infected HCBs and their uninfected family members in such areas as family support and suicide prevention.

d. Use local assets to support command and public information efforts.

e. Consult, as appropriate, with the servicing staff judge advocate (SJA) on the limited use provisions of this policy and other restrictions on the use of HIV information.

f. Ensure that all senior military (major and above) and civilian personnel (GS-11 (or equivalent) and above) receive comprehensive training and education on HIV infection and Army policies. Managers and supervisors of civilian employees should attend a presentation of the DA-sponsored "AIDS in the Workplace" training program. Commanders should ensure that all nonsupervisory civilian employees are given sufficient training regarding HIV/AIDS in the workplace so that—

(1) Fear of exposure to HIV or AIDS through casual contact in the workplace is reduced or eliminated, and

(2) Employees have sufficient knowledge about the disease so that they can take appropriate action to reduce risk behaviors.

g. Ensure that information regarding HIV testing results is appropriately safeguarded per the policies in this regulation.

1–13. Unit commanders

Unit commanders will—

a. Be knowledgeable of the provisions of this regulation.

b. Ensure that HIV information and education is included in unit training programs, with emphasis on the prevention of infection.

c. Ensure their assigned/attached personnel comply with the HIV testing requirements.

d. Accompany soldiers identified as HIV antibody positive during initial notification. (Unit commanders who are general officers may designate a subordinate officer to perform this function). Commanders may be present during the initial notification (although they need not be present), but will not be allowed to remain during the epidemiological assessment interview between the physician and the HIV-infected soldier.

e. Provide support and facilitate the support network for the HIV-infected soldier during the initial notification and subsequent evaluation.

f. Protect HIV-infected soldiers from unwarranted invasions of their privacy. This responsibility includes limiting disclosure of a soldier's HIV antibody status to only those personnel who have a need to know about the medical condition in the performance of their duties, and ensuring that the recipient of the information understands his or her obligation to protect the confidentiality of that information.

g. Consult, as appropriate, with the servicing SJA on the limited use provisions of this policy and other restrictions on the use of HIV test results and epidemiological information.

h. Counsel HIV-infected soldiers per the policies in paragraph 2–14 immediately following formal preventive medicine counseling.

i. Ensure that HIV-infected active duty soldiers report for scheduled medical evaluations at military medical treatment facilities (MTF).

Section III
Policies

1–14. General

HQDA medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection, the risks to the infected individual incident to military service, the risk of transmission of the disease to noninfected personnel, the overall impact of infected personnel in Army units and on readiness posture, and the safety of military blood supplies. The following are established policies on HIV:

a. HIV-infected persons are not eligible for appointment or enlistment into the Regular Army (RA), the ARNG, or the USAR. (See chap 3.)

b. All active duty (AD) and RC personnel designated in chapters 2, 4, and 5 will periodically be tested and retested for evidence of HIV infection. Frequency of testing will be jointly determined by ODCSPER and OTSG based on available medical and epidemiological evidence.

c. Medical follow-up and evaluation will be conducted periodically for all HIV-infected HCBs. (See chap 2 and 6.)

d. Except for those identified during the accession testing program (chap 3), HIV-infected soldiers who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations will not be involuntarily separated solely because they are HIV-infected. (See chap 2, 4, and 7.)

e. HIV-infected AD soldiers, including Active Guard/Reserve (AGR), will be permanently limited to duty within the United States (including Alaska, Hawaii, and Puerto Rico). HIV-infected soldiers currently assigned outside the United

States will be reassigned to the United States per AR 614–30 and this regulation. Direct coordination with Commander, U.S. Total Army Personnel Command (PERSCOM), Commander, GuardPERCEN, ATTN: NGB–ARP–CT (for ARNG AGR Title 10 personnel), or Commander, ARPERCEN, ATTN: DARP–AR (for USAR AGR personnel), will be made to ensure expeditious reassignment of HIV-infected soldiers. (See chap 4.)

(1) The duty limitation discussed above does not apply to RC personnel who reside overseas, or to AD soldiers who are permanent residents of, and are currently stationed in, Guam, the Virgin Islands, or American Samoa. It does, however, apply to all AD soldiers not currently assigned to these locations, regardless of permanent residence.

(2) HIV-infected soldiers outside these areas who desire compassionate reassignment to these areas may apply per existing policy for compassionate reassignments. Requests will be considered on their merits on a case-by-case basis.

f. Conditions of national emergency and/or mobilization and deployment overseas may require reordering of priorities for screening and assignment of HIV-infected soldiers, but will not affect overseas assignment limitations. For readiness (including unit status reporting and emergency deployment readiness exercises) and mobilization purposes, AD soldiers are considered deployable if they have a negative HIV antibody test recorded within 24 months of scheduled deployment (or date of unit status report). RC soldiers are considered deployable if they have a negative HIV antibody test recorded within 5 years of scheduled deployment (or date of unit status report). However, upon mobilization, all soldiers being ordered or called to active duty will be tested for HIV antibodies within 24 hours of reporting to their mobilization station if there is no record of a negative HIV test within the previous 24 months. Initial enzyme-linked immunosorbent assay (ELISA) HIV test results will normally be available within 48 hours. Soldiers will not be deployed until test results are known. If the test results are negative, the soldier is considered deployable. If the initial test results are positive, the soldier will be removed from further processing until confirmatory tests are conducted and results are known. AD soldiers whose confirmatory HIV tests are positive will be assigned per paragraph e above. RC soldiers being called to AD under mobilization conditions whose confirmatory HIV tests are positive may be assigned per paragraph e above if the Assistant Secretary of the Army (Manpower and Reserve Affairs) (ASA(M&RA)) has authorized HIV-infected RC soldiers to be ordered to extended AD (EAD) under the mobilization conditions. HIV testing will continue at MEPS and training centers during mobilization.

g. HIV-infected soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and will be processed for physical disability under AR 635–40. (See para 4–12.)

h. It is essential that HIV-infected soldiers be encouraged to provide accurate information during the epidemiological assessment process. Accordingly, the mere presence of the HIV antibody or other medical evidence of HIV infection alone will not be used as the basis for adverse action against a soldier. (See chap 7.)

i. Soldiers found to be HIV-infected will be designated as "donor ineligible" in their medical and dental records. As part of the commander's counseling, they will be counselled and ordered not to donate blood, sperm/semen, tissues, or body organs due to the risk of HIV transmission to recipients. (See chap 2.)

j. Mandatory testing of civilians (to include family members) is not authorized, with the exception of those specific situations that may be defined and approved by DOD. Those situations will be published by HQDA (DAPE–CP or DAPE–HR) as they occur. Voluntary testing will be made available to all HCBs and civilian health care providers per chapter 6.

k. Except as stated below, civilian employees who have been diagnosed as HIV-infected or having AIDS will be treated no differently than other employees. They will be permitted to continue to work so long as their performance is acceptable and they do not pose a significant safety or health threat to themselves or others. If serious performance or safety problems arise, managers and supervisors should address them by applying existing Federal and Army civilian personnel policies and practices. Further guidance is available in chapter 6.

l. There is no basis for civilian employees to refuse to work with fellow employees, soldiers, or agency clients who have, or are suspected of having HIV infection or AIDS. The concerns of such employees will be addressed with education and counseling as appropriate. If an employee's continued refusal to work with a person with HIV infection or AIDS results in disruption in the workplace, appropriate disciplinary action may be taken against the employee. Further guidance is available in chapter 6.

m. Civilian employees with HIV infection or AIDS are considered "handicapped employees" within the meaning of the Rehabilitation Act of 1973 (29 USC 701 et. seq.) and, if otherwise qualified, are entitled to reasonable accommodation.

n. All information regarding HIV testing results will be handled in a manner to prevent unauthorized access to the information. Access to such information will be permitted only for those individuals who have a legitimate medical, administrative, or legal need to know that information in the performance of their duties.

o. News media inquiries concerning HIV/AIDS policies, testing, or issues will be handled as follows:

(1) Routine news media queries on a local level will be directed to the appropriate PAO.

(2) Media queries concerning Army HIV/AIDS policies should be referred to OCPA, Media Relations Division.

(3) HIV testing statistics will be released only in response to specific query. Such inquiries must be processed under the provisions of the Privacy Act (5 U.S.C. 552a) and the Freedom of Information Act (FOIA) (5 U.S.C. 552) and should be handled in accordance with the procedures of AR 340–21, The Army Privacy Information Act Program.

Generally, HIV information about specific individuals will not be released under the FOIA, but may be released under the Privacy Act if the requester is the subject of the records. In order to prevent accidential disclosure of HIV information that may be attributable to specific individuals, statistics may only be released for major installations (see gloss) or major commands.

p. Policies contained in this regulation will be reviewed as developments occur in scientific and/or medical knowledge, or issuance of revised DOD policies dictate.

1–15. Not Used

Chapter 2
Testing and Counseling Procedures

Section I
General Overview

2–1. General

a. A testing, counseling, and surveillance program for HIV infection is necessary to—

(1) Ensure the continued readiness and deployability of the total force.

(2) Preserve the health of DA personnel and their families by identifying HIV-infected HCBs and providing appropriate counseling and medical treatment.

(3) Determine fitness for military duty.

(4) Permit commanders to assess the readiness, security, military fitness, good order, and discipline of their commands and to take appropriate action based upon such assessment.

(5) Avoid potential complications of, and adverse reactions to, immunizations among HIV-infected individuals, particularly new accessions to active duty.

(6) Provide data as a part of a longitudinal follow-up study of HIV infection as it affects DA personnel and their families.

(7) Develop scientifically based information on the natural history and transmission pattern of HIV.

b. The presence of HIV antibodies in the blood is an indicator of infection with HIV, the causative agent of AIDS. For medical classification purposes, HIV infection has been divided into six stages based upon varying degrees of immuno-incompetence and disease severity.

(1) Stages 1 and 2 are the earliest stages of infection and are characterized by presence of the HIV antibody; however, there are generally no symptoms or clinical evidence of immuno-incompetence.

(2) Stages 3 through 5 are characterized by increasing clinical evidence of deterioration of the immune system, culminating in the body's inability to resist infection.

(3) Stage 6 is the final, most serious stage, characterized by severe opportunistic infections usually resulting in death. However, neurological complications and other signs and symptoms may occur at any stage of the disease.

c. HIV-infected HCBs will be medically evaluated to determine the status of their infection. The standardized DOD clinical protocol will be used for all AD soldiers. HIV-infected RC soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 or NGR 40–501 and be found fit for duty per standardized DOD clinical protocol. RC soldiers are required to obtain the fitness for duty medical examination from the civilian medical community at no expense to the government. The medical procedures to be used or performed will be provided to the soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. See chapter 5 for additional guidance regarding disposition of HIV-infected RC soldiers.

2–2. Overview of HIV testing program

The HIV testing program (other than screening of new accessions) includes—

a. Blood donor testing. All military blood donors will be screened for the HIV antibody. AD HIV-infected soldiers will be referred to a MTF for evaluation per DOD-approved clinical protocol. HIV-infected soldiers (both AD and RC) identified during civilian blood drives on military installations will be reported to military medical authorities for followup evaluation.

b. Suspicious illnesses. All AD soldiers with signs and/or symptoms compatible with or suggesting HIV infection, such as lymphadenopathy (enlarged lymph nodes), unexplained lymphopenia or leukopenia (depressed white cell count), neurological disease, adult oral candidiasis (thrush), or evidence of opportunistic infections (such as pneumocystis pneumonia or candida esophagitis), will be tested in either the outpatient or inpatient setting as part of the medical evaluation.

c. Patients with sexually transmitted diseases (STD). These patients are seen mainly in STD, OB-GYN, urology, or

dermatology clinics, but may be seen in any MTF clinic or ward. Each new STD infection, to include gonorrhea, nonspecific urethritis, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, genital herpes, and sexually transmitted hepatitis B, requires an HIV antibody test to be given with 3- to 6- and 12-month followup tests if the initial HIV test is negative. Such procedures are necessary to detect seroconversion in latent infections. AD soldiers who present with an STD will be tested for HIV. Patients found to be HIV-infected will be evaluated per paragraph 2–12d.

d. Blood transfusion/blood product recipients. The policies of the Armed Services Blood Program and guidelines of the Food and Drug Administration (FDA) will be followed in the DA Blood Program and by civilian blood agencies collecting blood on Army installations.

(1) Soldiers who received blood transfusions or blood products after 1 January 1978 and prior to 1 July 1985 (the date routine HIV antibody screening of blood products began) will be identified, contacted, and tested for the presence of the HIV antibody.

(2) Blood or blood product donors whose donation tests positive for the HIV antibody will be notified, counseled, and evaluated as required by this regulation.

(3) Recipients of blood products obtained from donors who are later determined to be HIV-infected will be located, notified of the potential risk, and tested and evaluated.

(4) Donors of blood or blood products whose donations were transfused to recipients who were later determined to be HIV-infected will be located, notified of their potential infection, and tested.

(5) Laboratory capability to perform ELISA testing will be maintained to support the Army Blood Program and to continue to provide backup coverage of testing initiatives.

e. Sexual partners.

(1) Soldiers who are, or have been, sexual partners of HIV-infected individuals will be tested. Although there are no documented cases of casual transmission of infection, soldiers who are household members with HIV-infected individuals and are not sexual partners will be offered testing if there is any anxiety over the potential for household or casual transmission.

(2) RC medical authorities will report information pertaining to HIV-infected RC soldiers through designated channels to the State or Continental U.S. Army (CONUSA) HIV Program POC. That information will, in turn, be provided to the State or local jurisdiction public health authority dealing with HIV/AIDS in accordance with State or local law or reporting requirements. Specific guidance for reporting this information is included in the detailed implementing instructions published by the National Guard Bureau (NGB) or OCAR.

f. Intravenous (IV) drug use. Soldiers known to have used drugs intravenously will be routinely screened for the HIV antibody.

g. Voluntary screening. Any soldier may voluntarily request screening and will be accommodated as soon as possible, confidentially, at fixed Army AD MTF. This service should be widely publicized and made easily accessible to encourage its use. Such testing must always be accompanied by thorough counseling. Individuals who engage in high risk behavior, such as having sex with known HIV-infected persons or having multiple sexual partners, will be encouraged to be tested.

h. Active duty surveillance testing. All AD soldiers will be routinely tested at least biennially. In the event that prioritization of testing is required due to resource constraints, screening will be accomplished in the following order:

(1) Soldiers and military units assigned, or pending assignment, to areas of the world where a moderate to high risk exists of contracting serious tropical infections, such as yellow fever, malaria, and dengue. Such areas include Central America, South America, the Caribbean, the Philippines, Southeast Asia, Thailand, Malaysia, Central Africa, East Africa, and Southwest Asia.

(2) Soldiers or units pending assignment or deployment to areas of the world where medical support will be limited. Included are assignments to remote areas where periodic evaluation of persons and monitoring of health will be difficult, such as Korea and the Far East.

(3) Units with contingency plans to deploy on short notice to areas of the world described in (1) and (2) above. Included are alert forces who must be deployed in 30 days or less and all personnel scheduled to participate in overseas exercises who have not been screened within 24 months of the projected deployment date.

(4) Other military units that could be deployed overseas and overseas Army forces in Europe, Korea, and Japan.

(5) All other units.

(6) All soldiers in conjunction with routine, periodic physical examinations for any purpose, or any other scheduled medical examinations.

i. ARNG and USAR surveillance testing.

(1) ARNG and USAR Selected Reserve screening will be conducted every 5 years.

(2) ARNG and USAR soldiers will also undergo HIV antibody screening as part of their periodic physical examinations. Patient privacy will be maintained in the same manner as required in active component MTF procedures. Specific policies and procedures for the ARNG and USAR are in chapter 5.

(3) If prioritization of testing is necessary, screening will be accomplished in the same order as in*h* above.RC

soldiers ordered to AD for more than 30 days will be considered priority 4 if they do not meet the criteria of priorities 1-3.

j. Routine adjunct testing.

(1) Each Army MTF will initiate and maintain a routine adjunct patient screening program for soldiers encompassing the following categories of patients, in addition to physician-ordered clinical testing:

(a) All soldiers admitted to Army hospitals unless tested during the preceding 12 months.

(b) All soldiers seeking care for STD. Testing should be repeated at 3 to 6 and 12 months to detect late seroconversion after potential exposure.

(c) All pregnant soldiers at the time of their initial prenatal evaluation. Testing will be repeated just prior to, or at the time of delivery, if the mother has been identified as being at high risk.

(d) All soldiers enrolled in the Army Alcohol and Drug Abuse Prevention and Control Program (ADAPCP) (Tracks II (individual counseling) or III (short term residential rehabilitation)).

(e) Complete (as opposed to limited or walk-in symptom focused) physical examinations will routinely include an HIV antibody screening test. This includes premarital examinations performed overseas under the provisions of AR 608–61.

(f) MTF and dental treatment facility (DTF) commanders may institute screening of soldiers scheduled for outpatient invasive procedures if resources are determined to be available.

(g) All soldiers requiring treatment in emergency rooms with evidence of trauma, such as shootings, stabbings, and rape.

(h) All soldiers with acute or chronic hepatitis B infection.

(i) All soldiers who are dead on arrival or who die in emergency rooms.

(j) All soldiers with physical evidence or history of recent IV drug use who require medical care. Testing should be repeated at 3 to 6 and 12 months to detect late seroconversion after potential exposure.

(2) AD patients may not refuse screening, but should be informed of the pending procedure. Each patient will be provided a copy of the Scriptographic booklet entitled, "HIV and AIDS," or an equivalent DOD-approved educational publication.

k. Overseas assignments. Active component (AC)/AGR personnel pending permanent change of station (PCS) overseas must be screened and test negative for HIV infection if they have not been tested within the 6 months preceding their port call. Individuals alerted for overseas assignments will be instructed, as part of their soldier reassignment processing requirements, to report to the appropriate physical examination clinic or laboratory for drawing of blood. The following policy applies:

(1) AC/AGR personnel scheduled for temporary duty (TDY) or deployments on exercises overseas that will not exceed 179 days must have tested negative for HIV infection within the 24 months prior to departure date.

(2) AC/AGR personnel scheduled for overseas deployments or TDY that will exceed 179 days must have tested negative for HIV infection within the 6 months prior to departure date.

(3) RC personnel scheduled for overseas duty (to include Guam, American Samoa, and the Virgin Islands) of 30 days or less must have a negative HIV test within the 5 years prior to departure date. All RC personnel performing active duty of more than 30 days require a negative HIV test within the 6 months prior to reporting date, regardless of whether the duty is overseas or in the United States.

(4) RC personnel located outside the United States scheduled for training either in the United States or overseas who do not meet the testing windows stated above will be tested immediately upon arrival at the training duty station when testing prior to departure is impractical.

l. Restricted assignments. Soldiers on orders for assignment to one of the units/programs identified in paragraph 4–2b must be screened and test negative for HIV infection if they have not been tested within the previous 6 months. Individuals alerted for these assignments will be instructed to report to the appropriate physical examination clinic or laboratory for drawing of blood. Soldiers testing positive for HIV will not be assigned to a restricted unit or program.

Section II
Functions of Medical Personnel

2–3. Medical personnel

Functions delineated below may be reallocated with concurrence of medical command commanders specified in paragraph 1–10.

a. Commander, Army MTF —

(1) Appoints a physician as the Clinical Manager. This physician may be an infectious disease specialist, an internist, or any other physician who possesses the necessary clinical skills.

(2) Appoints the Installation Area HIV Program Director (HIV Program POC). This individual may be the Clinical Manager or Preventive Medicine Physician. This director has overall responsibility in the allocation of all available

HIV/AIDS resources, supervision of the local HIV team, interaction with all appropriate military and civilian agencies, and other related duties as assigned by the MTF commander.

(3) Monitors and ensures implementation of the program as outlined in this regulation.

b. Preventive Medicine Physician (PMP)—

(1) In conjunction with the appropriate commander, notifies all AD personnel of initial or confirmed positive HIV test results.

(2) Notifies all non-active duty HCBs of initial or confirmed positive HIV test results, unless notification has been accomplished by the physician ordering the test.

(3) Provides initial counseling at the time of notification to all newly identified HIV-infected HCBs.

(4) Receives results from the clinical laboratory manager identifying all potential new cases of HIV infection.

(5) Coordinates referral of newly identified HIV-infected HCBs to the clinical managing physician.

(6) Establishes a registry of all known HIV- infected HCBs residing within the facility health service region (HSR).

(7) Ensures that blood donation and recipient information provided by HIV-infected persons during epidemiological interviews is collected utilizing DA Form 7303 (Donor/Recipient History Interview Form). DA Form 7303 is available through normal publications channels. A sample of DA Form 7303 is at figure 2–1. The PMP will ensure these forms are reviewed and appropriate look-back efforts initiated. Also, the PMP will ensure that personal identification data pertaining to newly identified HIV-infected persons is provided to appropriate blood bank officials at the MTF or, if indicated, to civilian authorities as required by DA, DOD, and appropriate jurisdiction law.

(8) Establishes a suspense mechanism to ensure initial and subsequent evaluations and other administrative actions are completed as required.

(9) Performs contact interviews.

(10) Locates, notifies, and counsels all military HCBs who are named contacts of HIV-infected persons, arranging for testing as necessary. If there are named contacts who should be notified but who do not reside in the facility HSR, provide necessary information to the appropriate PMP for followup.

(11) Provides local, State, or host nation public health authorities with all pertinent contact information in accordance with applicable statutes and this regulation.

(12) Completes designated parts of HIV data collection forms and submits them to the U.S. Army HIV Data Base System (USAHDS) within 90 days of the date of beginning initial staging.

(13) Ensures that communicable disease reporting requirements established in Federal, State, or local public health statutes are fulfilled.

(14) Prepares and submits reports as required by local authorities and higher headquarters, ensuring that disclosure of any HCB's HIV status is based on medical or administrative "need-to-know" only.

(15) Serves as POC for receipt and transfer of health records pertaining to HIV-infected HCBs.

(16) In conjunction with the MTF patient administration officer, ensures that all medical and dental records are properly marked and annotated per this regulation and other applicable references. Ensure medical/dental records of HIV-infected patients are available for use in emergency treatment facilities.

(17) Serves as the medical clearance authority for HIV status for personnel processing for overseas reassignment.

(18) Coordinates the force surveillance testing program.

(19) Provides prompt letter notification to appropriate command authorities when soldiers are suspected of having engaged in unprotected sexual relations or other high-risk behaviors which could have transmitted the infection to others.

(20) Notifies the commander of MTF and DTF of all HIV-infected HCBs.

(21) Assists the ARNG and USAR in notification of local public health authorities of HIV-infected RC soldiers residing within their geographic region. The State or CONUSA HIV POC will notify the PMP of statistical information necessary for reporting purposes.

c. Clinical Manager or attending physician—

(1) Schedules or performs initial medical evaluation physical examinations for all newly identified HIV-infected HCBs.

(2) Refers all newly identified HIV-infected HCBs to the PMP or community health nurse (CHN) for administrative and public health followup.

(3) Provides followup evaluations and restaging for HIV-infected HCBs residing in the facility's HSR, submitting restaging reports through the PMP to the USAHDS.

(4) Provides primary care for all HIV-infected HCBs and coordinates any specialty care required.

(5) Reports to the PMP all instances where HIV-infected soldiers or family members are suspected to have engaged in unprotected sexual relations or other high-risk behaviors that could have transmitted the infection to others.

(6) Reports to the PMP any previous history of blood or tissue donation by the HIV-infected HCB.

d. Installation HIV Program Manager —

(1) Coordinates and/or provides HIV education programs for unit-level training within the HSR.

(2) Coordinates HIV education for HCBs tested under the routine adjunct patient screening program.

(3) Coordinates HIV education programs for military community groups as requested.

(4) Provides counseling for all HCBs as appropriate.

(5) Assists the PMP in performance of contact interviews, family counseling, force testing responsibilities, and administrative functions.

e. Clinical Laboratory Manager/Blood Bank Officer —

(1) Coordinates obtaining unit-level and individual blood specimens for testing required by this regulation and other references.

(2) Maintains data concerning force testing and clinical screening, including the number of specimens drawn, the number submitted, results of initial testing, and results of confirmatory testing.

(3) Ensures compliance with guidelines for obtaining, processing, labeling, packaging, shipping, and storing specimens.

(4) Serves as local POC for matters pertaining to contracted laboratory support.

(5) Ensures that results from HIV testing performed within the local laboratory are captured using the HIV Test Result Recording System (HIVTRRS) per DA guidance.

f. Physicians, dentists, hospitals, medical and dental clinical laboratories, and other health care facilities will promptly notify the appropriate supporting military health care facility whenever laboratory examination of any specimen derived from the human body yields microscopic, cultural, immunologic, serologic, or other evidence suggestive of HIV infection. This information will be handled per existing regulatory procedures governing patient privacy.

2–4. Medical support

a. Blood drawing and initial processing of sera from AD soldiers being tested under the force surveillance program, RC personnel upon prior arrangement, or patients participating in routine adjunct testing will be accomplished by existing medical resources, under the direction of the clinical laboratory manager or other qualified person as directed by the PMP.

(1) U.S. Army Medical Command (USAMEDCOM) will provide and/or coordinate necessary resources for testing support in the United States (including Alaska and Hawaii) and Panama.

(2) In Europe, the Landstuhl Army Regional Medical Center, under guidance of USAMEDCOM and OTSG, will support all Army personnel by collecting and processing specimens, performing ELISA testing, and shipping ELISA positives to the continental United States (CONUS) for confirmation testing.

(3) Army personnel stationed in Korea, Japan, and the Pacific area will be supported as in (2) above by Tripler Army Medical Center (TAMC), under guidance of USAMEDCOM and OTSG.

(4) Army personnel in Central and South America will be supported by Gorgas Army Hospital, under guidance of USAMEDCOM and OTSG.

b. Civilian contract support will be used as discussed below.

(1) Central contracting for HIV screening and confirmation testing is the responsibility of OTSG, with support from USAMEDCOM and USAMRMC.

(2) Contract testing will be used for accession, force surveillance, and routine adjunct testing. Contract testing allows close quality control and automated collection of testing data for suspensing future testing and research. All supplies necessary for the MTF to obtain, package, and ship specimens will be supplied by the contractor.

(3) For Reserve component surveillance testing, contracts will require the contractor to perform transportation and testing of blood.

(4) HIV screening (ELISA only) capability will be maintained at all Army inpatient MTF to meet in-house requirements for HIV antibody testing of blood donors or in time-sensitive patient care activities. Under unusual circumstances, it may be necessary to perform force or routine adjunct testing using local resources. However, while such use is permissible to meet very limited objectives, long term or routine use of local, in-house resources for these purposes is not authorized. Not only is contract testing generally the more economical alternative, but quality control of results is enhanced, confidentiality is improved, data collection for the Standard Installation/Division Personnel System (SIDPERS) and research purposes is more complete, and interference with other patient care activities is minimized.

(5) HIV screening or confirmatory tests by other than DOD uniformed MTF or contract sources are not acceptable to meet any testing requirement established in this regulation.

Section III
HIV Testing Procedures

2–6. General HIV testing procedures

HIV antibody testing will include a screening test of all personnel designated in this regulation and confirmatory tests of those who test positive.

a. The screening test for the HIV antibody will be an FDA-approved ELISA test. The confirmatory test will be the immunoelectrophoresis (Western Blot) test, or a comparable test approved by OTSG after coordination with the Office of The Judge Advocate General (OTJAG) and the Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)). Testing will be as follows:

(1) Personnel whose initial blood specimen is Western Blot positive will be retested using a new blood specimen.

(2) If the results of the second test are negative, a third test will be performed on a fresh specimen. If results of either the second or third test are positive, the soldier will routinely be medically evaluated for HIV infection at a designated Army MEDCEN.

(3) If the results of the second and third tests are negative, the soldier is not infected. However, PMPs will report these instances to the appropriate MACOM Laboratory Officer.

(4) Actions to be taken regarding HIV-infected soldiers are described in chapter 4 for AD soldiers and chapter 5 for RC soldiers.

b. Medical authorities will promptly report to the soldier's command authorities the fact that a soldier has been confirmed HIV antibody positive.

c. Medical and command personnel will take necessary steps to ensure that test results are not disclosed except as required for medical, administrative, or legal purposes on a "need to know" basis for the performance of official duties.

2–7. Active force surveillance testing

a. All soldiers are required to be tested for the presence of HIV antibodies at least biennially (once every two years).

b. The basic method of monitoring compliance with this periodic testing requirement is a birth month screening for each soldier. A data field on the SIDPERS Personnel File (SPF) shows the last recorded HIV test date on SIDPERS. The HIV test date appears on DA Form 2A and 2B (Personnel Qualification Record, Part I) in section IV, Service Data, item 21. The installation HIV Program Manager should maintain a separate database to record all HIV testing for any reason.

c. Unit commanders are notified of all personnel requiring birth month HIV testing via a SIDPERS AAC–C18 report (HIV Screening Roster) (or a similar report of local design). The C18 report is sent to unit commanders by the servicing Personnel Service Center/Company (PSC) on a monthly basis. Since soldiers may be tested for reasons other than periodic force testing, such as during a physical examination, the date of last HIV test may not coincide with previous force surveillance testing. If a soldier listed on the C18 report was last tested more than 12 months previously, an HIV test is required in order to ensure the soldier's test does not become older than 24 months before his or her next birthday. Soldiers whose HIV test is older than 24 months are nondeployable. Soldiers whose last HIV test is 12 months old or less do not require an HIV test.

d. If HIV test date information is maintained by the installation HIV Program Manager, it may be used to manually update the C18 to determine soldiers requiring an HIV test. HIV test dates are automatically updated in SIDPERS based on HIV testing done by the contractor and computer tapes prepared by the contractor and sent through WRAIR to the Personnel Information Systems Command. HIV test dates are then automatically downloaded from the Officer Master File (OMF)/Enlisted Master File (EMF) to the SIDPERS Personnel File (SPF), normally 90 to 120 days after the test. Local SIDPERS transactions are not required to update item 21, DA Form 2A/2B. However, local SIDPERS transactions may be submitted to update the HIV test date when supported by a later date recorded on SF 600 (Health Record-Chronological Record of Medical Care) or SF 557 (Miscellaneous) from the soldier's medical records. The ad hoc query capability of the Tactical Army Combat Services Support Computer System (TACCS)/SIDPERS to access the personnel information file is authorized for use in lieu of the C18 report to determine the last HIV test date. In addition, the Defense Eligibility Enrollment System (DEERS)/Real-time Automated Personnel Identification System (RAPIDS) records the date of the last HIV test, and this date may be used in lieu of that on the C18 report.

e. HIV testing that is accomplished and properly recorded per other provisions of this regulation fulfills the biennial force surveillance testing requirement. Force surveillance testing results may only be substituted for other testing requirements if all criteria for the other requirements are met. For example, a force surveillance test will fulfill the requirement to screen prior to departure for an overseas assignment only if it was completed within the 6 months prior to departure.

f. The birth month method of biennial testing is DA policy. However, in recognition of unique mission requirements, commanders may desire to use an alternate method. Requests for exceptions to the birth month requirement will be submitted through command channels to HQDA(DAPE–HR–PR). Requests will provide details of the proposed alternate method and rationale for proposing the alternate method. Any higher commander in the chain of command may disapprove a request for exception to the birth month HIV test requirement. Alternative testing methods will not be implemented prior to approval by DA.

2–8. Reserve Component surveillance testing

a. ARNG and USAR Troop Program Unit (TPU) surveillance testing will normally be accomplished as part of the periodic physical examination (see para 2–2i(2)).

b. Soldiers assigned to the Individual Ready Reserve (IRR) and Individual Mobilization Augmentation (IMA)

programs will be tested during annual training (AT) or active duty for training (ADT), if their last HIV antibody test is older than 4 years, and during periodic physical examinations, including flight physicals. IRR and IMA soldiers' physical examinations that are performed by civilian contract will be considered "interim complete" if the soldier has a documented HIV test no older than 5 years. Under this circumstance, an HIV test will be required within 48 hours of reporting for any active duty period to ensure the physical examination is updated.

2–9. Clinical evaluation

All AD personnel determined to be HIV-infected will be evaluated at the MEDCEN supporting the HSR. The evaluation will be conducted per standard DOD clinical protocol and will be reported as required in this regulation.

Section IV
Reporting and Recording of Information

2–10. Medical records

Information on, and results of, HIV testing will be entered in individual medical records as follows:

a. For force surveillance testing, an entry will be made on SF 600 (Chronological Record of Medical Case), which will include the date and location of testing. Recording of test results in the medical record of AD soldiers is required when the soldier is being processed for overseas permanent change of station (PCS). HIV test results for the ARNG and USAR will be annotated on SF 600 which will be posted in the medical record. The HIV test date and result will be annotated on SF 88 (Report of Medical Examination), item 50, if the test was performed in conjunction with a physical exam.

b. Results of routine adjunct testing will always be recorded in the medical record per AR 40–66 using SF 557. The slip will be clearly stamped either "HIV positive" or "HIV negative." Specimens which are ELISA positive by local testing only will not be reported as HIV positive. These specimens will be reported as "pending results" to the ordering physician, and finally reported as HIV positive or negative only after receipt of confirmatory test results (Western Blot or other supplementary tests).

c. The medical and dental record jacket for all HIV-infected soldiers will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) per AR 40–15. The master problem list will be annotated "Donor Ineligible-V72.62."

d. Records pertaining to staging and evaluation of HIV-infected soldiers will be filed per AR 40–66.

2–11. Command notification and profiling

a. Information on HIV-infected soldiers will be handled in a sensitive manner. Directors of Health Services, MEDDAC/MEDCEN commanders, command surgeons, unit surgeons, and clinic commanders will coordinate efforts in notifying individuals, commanders, and PSCs.

b. Soldiers who are confirmed as HIV-infected do not require a change in their physical profile solely because they are HIV-infected. If the soldier's physical/medical condition warrants a change in physical profile, a DA Form 3349 (Physical Profile) will be issued by the MEDDAC/MEDCEN commander or other profiling authority. Copies of the DA Form 3349 will be sent to the unit commander and the servicing PSC. Documents will be sealed in an envelope marked "To Be Opened By Addressee Only" and addressed, by name, to the appropriate unit commander and adjutant general or personnel officer. Procedures will be established by the appropriate medical authority to confirm that unit commanders and adjutants general/personnel officers have received proper notification of HIV-infected soldiers. If a change in physical profile is warranted, the following minimum entries will be made on the DA Form 3349:

(1) Item 1 of the DA Form 3349 will indicate the specific medical condition causing the change in physical profile. The profiling authority should avoid referring to HIV infection or retrovirus infection since these terms describe the disease process rather than the specific medical condition resulting in the profile.

(2) Item 2 will contain an appropriate numerical designator under the appropriate factor in the physical profile.

(3) Additional codes may be entered as necessary.

(4) Item 3 will indicate any appropriate assignment restrictions based on the soldier's medical condition.

2–12. Individual notification procedures

All soldiers will be individually and privately notified of all positive HIV test results in a face-to-face interview with a physician.

a. In HSC, the contractor will notify the laboratory officer designated at each MTF of the identity (by assigned laboratory specimen number) of specimens that test positive or negative by Western Blot. This notification will be accomplished by electronic facsimile transmittal. In the 18th MEDCOM, the laboratory officer will be notified by message. The referring laboratory will be sent an information copy. The 7th MEDCOM will be notified telephonically, followed by hard copy.

b. The designated physician will notify the soldier of the initial HIV positive test. The individual will be informed that they have a positive Western Blot and that it may mean he or she is infected by HIV. If confirmed to be infected

by a second or subsequent test, they will be referred for further medical evaluation. Individuals will be advised not to donate blood, tissues, organs, or semen and to refrain from sexual relations until the results of the confirmatory tests are available. The physician will ensure the soldier understands that continuing to have sexual relations before the results of confirmatory tests are available places their sexual partner at risk of infection if the soldier is confirmed to be HIV-infected.

c. Unit commanders will formally counsel soldiers immediately after, but not before, the post-diagnosis preventive medicine counseling performed by Army Medical Department (AMEDD) personnel as prescribed in paragraph 2–13.

d. All AD personnel confirmed to be HIV-infected will be referred to a MEDCEN for medical evaluation and staging. Reevaluations of all HIV-infected personnel will be accomplished as appropriate, but at least semi-annually.

e. Within 30 days, soldiers whose tests are negative will be notified of the results by direct mail on DA Form 5668 (HIV Screening Test Results) and will be required to retain a copy of the form. DA Form 5668 is available through normal publications channels. A sample of a completed DA Form 5668 is at figure 2–2.

f. Notification of contacts of HIV-infected personnel will be as follows:

(1) Soldiers will be advised by medical authorities to immediately notify their spouse and/or their sexual partners of their infection. They will also be advised that medical authorities will followup to ensure that this has been done as provided below and in chapter 6.

(2) Military personnel who are sexual partners of known AIDS patients, individuals who are HIV-infected, or individuals who were transfusion or blood product recipients from HIV-infected donors will be advised by medical authorities of their possible exposure and will be tested for HIV antibodies.

(3) Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating that individuals—

(a) Who are not military personnel or military HCBs are sexual partners of known AIDS patients or of people who are HIV-infected, or

(b) Were transfusion or blood product recipients from HIV-infected donors.

Section V
Counseling Procedures

2–13. Preventive medicine counseling

a. HIV-infected individuals will be provided preventive medicine counseling on the relationship between HIV, the blood tests, and AIDS; the risks of disease transmission to close personal contacts and family members; methods of prevention; and the fact that HIV-infected individuals are not eligible to donate blood, tissues, organs, or semen. The counseling will be recorded using DA Form 5669-R (Preventive Medicine Counseling Record). A copy of this form is located at the back of this regulation. This form may be reproduced on 8 ½ x 11-inch paper.

b. Each soldier who is identified as HIV-infected will be provided with accurate information concerning the infection and disease process and counseled regarding transmission. The following are specific elements to be included in the counseling:

(1) The positive ELISA antibody test with Western Blot confirmation means that the patient has been exposed to, and is infected with, HIV. Current medical knowledge indicates that once a person has been infected, as indicated by a positive Western Blot HIV antibody test, he or she will continue to harbor the virus. This means that an HIV antibody positive person is infectious and capable of transmitting the virus through any behaviors involving exchange of body fluids. Blood, semen, and vaginal/cervical secretions are associated with the greatest risk of virus transmission.

(2) Casual contact poses negligible risk of transmission. HIV infection has been shown to be primarily transmitted through three routes: intimate sexual exposure; perinatal exposure (from infected mothers to their infants); and parenteral exposure (such as transfusion of contaminated blood or sharing of needles by intravenous drug users). Since the virus has been isolated from various body fluids (to include blood, semen, vaginal/cervical secretions, saliva, tears and breastmilk), personal items such as toothbrushes and razors that could become contaminated with blood or other fluids should not be shared with others, even though the risk appears low.

(3) There is no evidence that the infection can be transmitted through insect vectors such as ticks, lice, or mosquitoes.

(4) HIV infection is not transmitted through food or water. HIV-infected foodhandlers pose no risk of transmission to others through preparation or serving of food.

(5) The percentage of those infected with HIV who will progress to clinical illness or suffer impaired immunity is unknown. However, estimates range from 50 to 100 percent over several months to years. For this reason, HIV-infected persons must have medical evaluations at least annually. If a previously non-symptomatic person should develop unexplained fever, weight loss, or infections, immediate medical attention should be sought.

(6) HIV is a sexually transmitted disease. While homosexual and bisexual males and intravenous drug users currently comprise the majority of HIV-infected persons identified thus far in the United States, the infection can also be transmitted heterosexually. There is evidence of transmission from male-to-female and female-to-male. Persons who

have many sexual contacts stand a much greater chance of being exposed to HIV. Prostitutes, male or female, represent a high-risk group since they have many sexual contacts and frequently are also intravenous drug abusers.

(7) Although no symptoms may be currently present, an HIV-infected person can transmit the infection to others through sexual intercourse, sharing of needles, or donating blood, tissues, organs, or semen. Transmission of infection to others can possibly occur through exposure to saliva or genital secretions while engaging in oral-genital contact or intimate (deep) kissing.

(8) Transmission of HIV infection through sexual intercourse can be avoided only through abstinence. If abstinence is not practiced as a means of prevention of transmission, then the HIV-infected person must engage only in "protected" sexual relations (i.e., using a latex condom). Males must always use a condom, and females must insist that their partners use condoms. While the efficacy of condoms in preventing transmission of infection is unproven, their use may reduce potential for transmission. Even when condoms are always used, the number of sexual partners should also be limited to reduce potential transmission.

(9) HIV-infected persons must verbally inform their sexual partners of their infection prior to engaging in behavior that potentially can transmit HIV. They are required to inform their spouse of their medical condition. Medical authorities will assist the soldier in this notification, as required. Sexual relations with a spouse is a decision that can only be made by the spouse after full counseling regarding the risks involved. The decision to engage in sexual relations or to use or not use condoms when engaging in sexual relations with a spouse is one which must be discussed by the spouses and ultimately determined by the spouse who is not HIV-infected.

(10) The HIV-infected soldier will be advised and encouraged to inform all sexual contacts of the likelihood of exposure to HIV, and to cooperate fully in the epidemiological assessment.

(11) Previous sexual partners of HIV-infected persons are to be advised to seek testing and counseling. If the partner is an HCB, the counselor will inform them of their potential exposure and encourage them to undergo testing and counseling. Persons who have shared needles with HIV-infected persons should also be tested and counseled.

(12) HIV-infected women will be advised of the risks of having an HIV-infected infant and counseled that it is medically advisable for her to avoid pregnancy. New mothers who are HIV-infected will be advised to avoid or discontinue breastfeeding to prevent potential transmission if her infant is uninfected.

(13) HIV-infected soldiers will be advised not to donate blood, sperm, tissues, bone marrow, or organs.

(14) Whenever HIV-infected soldiers seek medical or dental care, they must always inform the health care provider of their HIV infection and any medications they are taking so that precautions are taken to ensure they receive the most appropriate care and to protect the health care provider and others.

(15) HIV-infected health care workers must wear gloves if they are required to come into contact with mucous membranes or non-intact skin of others. Those with an exudative lesion or weeping dermatitis will be removed from direct patient contact until the condition clears; they are to fully comply with the U.S. Public Health Service guidelines on prevention of transmission of HIV infection in a health care setting. Any duty or practice restrictions placed on HIV-infected health care workers will be per chapter 4.

2–14. Commander's counseling

a. Commanders will formally counsel soldiers who test positive for the HIV antibody. For active duty personnel, command counseling will be performed immediately after, but not before, the post-diagnosis preventive medicine counseling performed per paragraph 2-13. For RC personnel, command counseling will be performed immediately following notification by a medical officer.

b. Commanders will use the sample DA Form 4856 (General Counseling Form) at figure 2–3 and ensure that all topics are addressed. Commanders will also ensure that completed counseling forms are maintained in a manner that protects the confidentiality of the information.

c. Counseling will include a direct order to verbally inform their sexual partners of their infection prior to engaging in intimate sexual or other behavior involving a significant risk of HIV transmission (such as behavior that would result in the exchange of blood or seminal fluid between persons). Counseling will also include a direct order to not engage in unprotected sexual relations (including, but not limited to, sexual intercourse, oral-genital, or anal-genital contact) with persons other than their spouse, or with their spouse unless the spouse freely and knowingly consents to such relations after having been informed of the soldier's infection. Counseling will also include a direct order to not donate blood, sperm, tissues, bone marrow, or other organs. Soldiers who willfully disobey this order may be considered for administrative or disciplinary action, as appropriate. Commanders should consult with their servicing SJA in appropriate cases.

d. The commander's copy of DA Form 5669-R and the commander's counseling record (DA Form 4856) will be maintained in unit files so long as the soldier is assigned to that unit. These records will be maintained in a manner that ensures only those persons with a valid need are allowed access. Upon the soldier's reassignment, the commander will forward the commander's copy of these records in a sealed envelope to the gaining commander. The envelope will be marked, "TO BE OPENED BY ADDRESSEE ONLY." Upon the soldier's separation, the commander's copy of these records will be destroyed. When the unit commander PCS, a commander's copy of DA Form 5669-R and DA Form

4856 will be provided to the new unit commander. The new unit commander will counsel the HIV-infected soldier in the same manner as that prescribed for new identified HIV-infected soldiers.

2–15. Psychosocial counseling

a. HIV-infected soldiers will be referred for psychosocial counseling as part of their initial medical evaluation. The purpose of this counseling is to provide an initial assessment of the soldier's mental state and coping skills. The HIV Program POC may refer the soldier to a mental health officer (as defined in DA Pam 600-24) and/or a Family Life Chaplain for this counseling.

b. The mental health officer or Family Life Chaplain should be skilled at counseling persons dealing with trauma, depression, and rejection. They should be specifically trained in identifying and dealing with potential suicides and personal grief. Training for those counselors who are not specifically trained in these skills will be provided by mental health officers or Family Life Chaplains who do have these skills. They may be assisted by other appropriate medical personnel.

c. Each subsequent medical evaluation of HIV-infected soldiers will include a psychosocial evaluation. This evaluation will assess the soldier's adaption to his or her diagnosis and can serve to direct the soldier to appropriate coping skill programs if needed.

d. Commanders may refer HIV-infected soldiers for additional psychosocial counseling as needed.

Section VI
Natural History of Disease Study

2–16. General study requirements

a. OTSG is conducting a longitudinal epidemiological evaluation of HIV-infected soldiers in the active duty force. Family members of active duty soldiers, RC soldiers, and other HCBs will also be followed, if possible. OTSG has established procedures to collect and evaluate data and identify trends.

b. OTSG will evaluate current policies based on an analysis of the collected data and epidemiologic evaluations and will recommend changes as warranted.

c. The initial and ongoing medical evaluation of each soldier found to be HIV-infected will include an epidemiological assessment of the potential for transmission of HIV to close personal contacts and family members. This information is vital to appropriate preventive medicine counseling and to continued development of scientifically based information regarding the natural history and transmission pattern of HIV. The limitations in chapter 4 regarding assignment, retention, separation, and disciplinary actions are intended to increase the validity of these assessments.

d. An ongoing clinical evaluation of the health status of each HIV-infected soldier will be conducted at least semiannually using the DOD protocol. Such evaluations will be conducted at designated Army medical centers.

2–17. U.S. Army HIV Data Base System (USAHDS)

OTSG has established and maintains a data base of individuals who are HIV-infected to support ongoing clinical evaluation and longitudinal epidemiologic evaluation. All epidemiological data for each case is collected in the data base (including names, social security numbers, and results of medical evaluation and staging). This system is covered under system notice A0040DASG/Medical Facility Administrative Records and A0040–666DASG–Health Care and Medical Treatment Record System. OTSG will disclose information from USAHDS only as follows:

a. To medical and command personnel to the extent necessary to perform their required duties.

b. To civilian public health authorities in accordance with local, State, or host nation statutes requiring such reporting and consistent with DOD policy.

c. To authorized personnel for the purpose of conducting scientific research, epidemiological assessment, management audits, financial audits, or program evaluation. Such personnel will not identify, directly or indirectly, any individual in any report of such research, assessment, audit, or evaluation, or otherwise disclose individuals' identities in any manner.

d. In response to an order of the judge of a court of competent jurisdiction, after coordination with HQDA(DAJA–LT), 901 North Stuart Street, Arlington, VA 22203–1837, at DSN 226–1613.

DONOR/RECIPIENT HISTORY INTERVIEW

For use of this form, see AR 600-110; the proponent agency is the ODCSPER

DATA REQUIRED BY THE PRIVACY ACT OF 1974.

AUTHORITY:	Title 5, United States Code *(USC)*, Section 301; Title 44, USC, Section 3101; and Title 10 USC. Section 1071.
PRINCIPAL PURPOSE:	To collect information from confirmed HIV infected individuals who indicate a past history of donating or receiving blood, blood products, organs*(s)*, tissue or sperm since 1977.
ROUTINE USES:	Information collected may be released to appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded on this form.
DISCLOSURE:	Disclosure of information requested is voluntary. However, failure to provide the required information may hinder lookback procedures.

1. NAME OF INDIVIDUAL *(Last, First, Middle Initial)*	2. CURRENT ADDRESS *(Number, Sreet, City, State)*
SMITH, ADAM F.	1113 WEST AVE. FORT KNOX, KY 40121

3. SOCIAL SECURITY NUMBER	4. TELEPHONE NUMBER *(Include area code)*	5. DATE OF BIRTH (Mo. Day, Yr)	6. SEX
123-45-6789	WORK: 624-5729 HOME: 624-8572	JUNE 15, 1971	[X] Male [ ] Female

7. I acknowledge that it may be necessary to release information to my confirmed HIV status by representatives of the Medical Advisory Committee of IRELAND ARMY HOSPITAL *(Medical Treatment Facility)* to the appropriate medical authorities in order to properly investigate the final disposition of any donations or recipient events recorded below. I hereby give permission for the release of this information.

Adam F. Smith *(Signature)* — 14 JAN 94 *(Date)*

Michaela L. Brennecke WITNESS *(Print/Type Name)* — Michaela L. Brennecke *(Signature)* — 14 Jan 94 *(Date)*

COL WILLIAM JONES *Medical Advisory, Point of Contact: (Name)* — 624-7523 *Telephone Number (DSN)* — (502) 624-7523 *(Commercial)*

8. Military Beneficiary Status *(Please Check appropriate category):*

Active [X] Dependent of Active Duty [ ] Sponsor's Name _____

Retired [ ] Dependent of Retired [ ] Sponsor's SSAN _____

Civilian [ ] Service Army [ ] Navy [ ]

Air Force [ ] Marine [ ] Other [ ] *(Identify)* _____

9. Have you donated any blood, blood product, organ*(s)*, tissue or sperm since 1977? *(Please check appropriate response.)*

YES [X] NO [ ]

10. If the answer to question #9 is YES, please indicate below the type and number of times you have donated. *(Please circle appropriate response and indicate the number of times below.)*

(Blood) / Blood Products Number 2

Organ (s) / Tissues Number _____

Sperm Number _____

11. For each donation indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available.

Donation #1 Type BLOOD Date *(Month, Day, Yr)* MAY 27, 1979

Name or Organization 97TH GENERAL HOSPITAL

Location FRANKFURT, GERMANY APO AE 09032 *(Street Address, City, State, Zip Code)*

Donation #2 Type BLOOD Date *(Month, Day, Yr)* OCT 15, 1993

Name or Organization FT KNOX BLOOD BANK

Location IRELAND ARMY HOSPITAL, FT KNOX, KY 40121 *(Street Address, City, State, Zip Code)*

DA FORM 7303, JAN 94

Figure 2-1. Sample of a completed DA Form 7303

Donation date and location continues. *(Please use additional sheets, if necessary.)*

Donation #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, Stqte, Zip Code)

12. Have you been the recipient of any blood, blood product, organ*(s)*, tissue or sperm since 1977? *(Please check appropriate response.)*

YES ☒ NO ☐

13. If the answer to question #12 is YES, please indicate below the type and number of times you have been a receipt. *(Please circle appropriate response and indicate the number of times below.)*

Blood / (Blood Products) Number 1

Organ*(s)* Tissues Number _____

Sperm Number _____

14. For each receipt indicated above please provide that date and location below. Please note that any and all documentation pertaining to the donation events indicated above should be utilized to ensure that accurate information is provided. If exact information concerning the locations or dates is not available, then please provide the information that is available. *(Please use additional sheets, if necessary.)*

Receipt #1 Type PLASMA Date *(Month, Day, Yr)* JUNE 9, 1977

Name or Organization 97TH GENERAL HOSPITAL

Location FRANKFURT, GERMANY APO AE 09032
(Street Address, City, State, Zip Code)

Receipt #2 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, State, Zip Code)

Receipt #3 Type _____ Date *(Month, Day, Yr)* _____

Name or Organization _____

Location _____
(Street Address, City, State, Zip Code)

15. REMARKS

REVERSE OF DA FORM 7303, JAN 1994

Figure 2-1. Sample of a completed DA Form 7303—Continued

HIV SCREENING TEST RESULTS

For use of this form, see AR 600-110; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority: 5 USC 301, 10 USC 3012(G).
Principal Purpose: To notify service members of the results of their HIV test.
Routine Uses: For notification purposes prescribed in AR 600-110; paragraph 2-15.
Disclosure: Disclosure is voluntary. However, failure to provide the information may result in incorrect identification.

NAME	SSN	DATE
BROWN, WILLIAM C.	123-45-6789	1 JUL 88

UNIT	GRADE
HHC 11th TRANS BN FT WILSON, NY 10100	SSG

The screening test performed on the blood specimen collected from you on the above date was ***NEGATIVE*** for the antibodies to HIV. The meaning of this result is that as of the date of the test, you have no detectible evidence of exposure to HIV. You should retain this test result with your yellow shot record *(International Certificates of Vaccination, PHS-731)* or some other readily accessible location as evidence of having been tested.

SIGNATURE OF MEDICAL AUTHORITY	TODAY'S DATE
	10 JUL 88

NAME AND TITLE OF MEDICAL AUTHORITY	TESTING FACILITY
JOHN S. SMITH, MAJ, MC CHIEF, PATHOLOGY SERVICE	ADAMS US ARMY HOSPITAL FT WILSON, HY 10100

DA FORM 5668, DEC 87 *(Fold on Dotted Line)*

Figure 2-2. Sample of a completed DA Form 5668

(Fold on Dotted Line)

ADAMS US ARMY HOSPITAL
FT WILSON, NY 10100

SSG WILLIAM C. BROWN
80 FIFTH ARTY RD
FT WILSON, NY 10100

PERSONAL--TO BE OPENED BY ADDRESSEE ONLY

STAPLE HERE *STAPLE HERE*

DA FORM 5668, DEC 87

Figure 2-2. Sample of a completed DA Form 5668—Continued

GENERAL COUNSELING FORM

For use of this form, see AR 635-200; the proponent agency is MILPERCEN

DATA REQUIRED BY THE PRIVACY ACT OF 1974

AUTHORITY: 5 USC 301, 10 USC 3012(G). PRINCIPAL PURPOSE: To record counseling data pertaining to service members.
ROUTINE USES: Prerequisite counseling under paragraphs 5-8, 5-13, chapters 11, 13 or section III, chapter 14, AR 635-200. May also be used to document failures of rehabilitation efforts in administrative discharge proceedings.
DISCLOSURE: Disclosure is voluntary, but failure to provide the information may result in recording of a negative counseling session indicative of the subordinate's lack of a desire to solve his or her problems.

PART I – BASIC DATA

1. NAME (last, first, MI)	2. SOCIAL SECURITY NO.	3. GRADE	4. SEX
Doe, John Q.	123-45-6789	E4	Male

5. UNIT	FOR TRAINING UNITS ONLY	
	6. WEEK OF TRAINING	7. TRAINING SCORES
HHC, 1st Training Brigade		HIGH____ MED____ LOW____

PART II – OBSERVATIONS

8. DATE AND CIRCUMSTANCES

The purpose of this command counseling is to inform you of DA and command policy regarding your responsibilities as a result of testing positive for the Human Immunodeficiency Virus (HIV) antibody. This counseling supplements and complements the preventive medicine counseling you received on 20 Dec 87.

9. DATE AND SUMMARY OF COUNSELING

I have been advised that you were counseled by Preventive Medicine personnel concerning your diagnosis of HIV positivity, the risk this condition poses to your health, as well as the risk you pose to others. You were advised by medical personnel as to necessary precautions you should take to minimize the health risk to others as a result of your condition. While I have great concern for your situation and needs, in my capacity as a commander, I must also be concerned with, and ensure the health, welfare, and morale of the other soldiers in my command. Therefore, I am imposing the following restrictions:

a. You will verbally advise all prospective sexual partners of your diagnosed condition prior to engaging in any sexual intercourse. You are also ordered to use condoms should you engage in sexual intercourse with a partner.

b. You will not donate blood, sperm, tissues, or other organs since this virus can be transmitted via blood and body fluids.

c. You will notify all health care workers of your diagnosed condition if you seek medical or dental treatment, or accident requires treatment. If you do not understand any element of this order, you will address all questions to me. Failure on your part to adhere to your preventive medicine counseling or the counseling I have just given you will subject you to administrative separation and/or punishment under the UCMJ, as I see fit.

DISPOSITION INSTRUCTIONS

This form will be destroyed upon: reassignment (other than rehabilitative transfers), separation at ETS, or upon retirement.

DA FORM 4856, JUN 85 EDITION OF JUL 84 IS OBSOLETE.

Figure 2-3. Sample of a completed DA Form 4856

Chapter 3
Accession Testing Program

3–1. General

This chapter prescribes the DA policy for accession testing and nonaccession of individuals confirmed HIV antibody positive by Western Blot test.

3–2. Accessions and probationary officers

a. For purposes of this chapter, accessions are—

(1) First enlistment in the RA or RC.

(2) Subsequent enlistment in the RA or RC other than immediate reenlistment in the same component.

(3) Original appointment as a commissioned or warrant officer in the RA (except for officer appointments in the RA under the provisions of AR 601–100, chap 2, secs V and IX through XII; and chap 6).

(4) Appointment as a cadet at the U.S. Military Academy (USMA).

(5) First original appointment as a commissioned or warrant officer in a RC (to include both qualification for Federal recognition and for original appointment as a Reserve of the Army in the ARNG following Federal recognition).

(6) The original appointment as a warrant officer in the Army of the United States (AUS).

(7) The peacetime order of a member of a RC to AD, ADT, or full-time National Guard duty (FTNGD) for the purpose of attending initial entry training, regardless of whether the RC member is programmed at the conclusion of training for release from active duty (REFRAD), or is programmed to continue on extended AD (EAD) or FTNGD. This specifically includes the order to EAD of Reserve commissioned officers commissioned through the Reserve Officer Training Corps (ROTC) program where the officer's initial duty assignment is to an officer basic course.

(8) Enrollment as an ROTC scholarship cadet or as a non-scholarship cadet in MS III.

(9) Enrollment as an officer candidate (Active Army, ARNG, or USAR) in Officer Candidate School (OCS).

b. Probationary officers are—

(1) RA commissioned officers on the AD list with less than 5 years active commissioned service.

(2) Commissioned officers of a RC who have less than 3 years commissioned service. Both AD and non-active duty commissioned service counts.

(3) Warrant officers who have less than 3 years service (AD or non-active duty) since original appointment in their present component.

(4) Officers who have less than 3 years service in the AUS without component.

3–3. HIV antibody testing policies

a. All applicants for accession (officer, warrant officer, and enlisted for the Regular and RC) will be screened for HIV antibodies using FDA-approved tests.

b. HIV antibody testing of applicants for enlistment will be accomplished during the initial physical examination at the MEPS. Blood samples will be drawn by medical personnel at the MEPS. Testing from any source except MEPS, other DOD military treatment facilities, or DOD contract facilities is not acceptable for accession testing requirements. (See AR 601–210, chap 5, sec XXII).

c. Applicants for accession who have no military status of any kind at the time of testing and who are confirmed HIV antibody positive will not be enlisted or appointed in any component of the Army.

d. Individuals who test HIV antibody positive will be provided a list of civilian treatment facilities by the chief medical officer at the MEPS. The chief medical officer will recommend the individual seek further medical evaluation at one of the listed facilities.

e. Accession testing will be conducted within the first 29 days of AD at training centers, schools, or units (whichever provides the earliest opportunity) for all personnel who have not been previously screened at a MEPS or other authorized location, or for whom 6 months have elapsed from the initial pre-accession screening (such as personnel entering from the delayed entry program or a pre-commissioning program). For accession purposes, the pre-accession HIV antibody test is valid until the soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the soldier will be retested within the first 29 days at the initial active duty installation. Those confirmed to be HIV-infected will be processed for separation for failure to meet procurement medical fitness standards.

f. Accessions processed by other than MEPS or an initial training center will follow a similar process as outlined above at the military point of entry. Vaccination with live virus vaccines may be administered provided there is a record of a previous negative HIV test no older than 24 months.

g. Prior service (PS) personnel required to meet accession medical fitness standards (AR 40–501, chap 2) must be tested and found to be HIV antibody negative no more than 6 months before enlistment in the Selected Reserve. PS applicants, not processed through a MEPS, may conditionally enlist without an HIV test, or with a test result older than six months. Testing is required within the first 30 days after enlistment through the force surveillance testing program. A one-time 30-day extension may be granted by the State Adjutant General or CONUSA commander. Soldiers testing HIV antibody positive will be discharged for an existed prior to service (EPTS) medical condition. Active duty soldiers transferring to or enlisting in a Selected Reserve unit at the end of his or her current contractual or statutory obligation without a break in service are required to meet retention medical fitness standards (AR 40–501, chap 3). These soldiers must have a negative HIV test no older than 24 months prior to the date of transfer or enlistment.

h. Candidates for Regular or Reserve officer service will be tested during pre-contracting, pre-scholarship, or pre-appointment physical examinations. This applies to any individual pending appointment as an officer in any officer procurement program, to include service academies, ROTC, direct commissioning, or OCS (National Guard, Reserve, or Regular Army) programs. For accession purposes, the pre-accession HIV antibody test is valid until the soldier is ordered to AD. Upon order to AD, if the pre-accession test is more than 6 months old, the soldier will be retested within the first 29 days at the initial active duty installation.

(1) USMA cadets who are confirmed HIV antibody positive will be separated from the Academy and discharged under USMA regulations. The Superintendent, USMA, may delay separation until the end of the current academic year. If the cadet is in his or her final academic year and is otherwise qualified, the cadet may be graduated without commission and discharged. An honorable discharge will be issued if HIV infection is the sole basis for discharge.

(2) ROTC cadets who are confirmed HIV-infected will be disenrolled from the program at the end of the current academic term (semester, quarter, or similar period). Cadets who are disenrolled due to HIV infection will be permitted to retain any financial support received through the end of the current academic term and such support is not subject to recoupment.

(3) Enlisted soldiers who are officer candidates through OCS and are confirmed HIV-infected will be immediately disenrolled from the program. If OCS is the soldier's initial entry training, the soldier will be discharged under the provisions of AR 635–200, paragraph 5–11. If OCS is not the soldier's initial entry training, the soldier will be removed from the program under the provisions of AR 351–5, paragraph 5–11; AR 140–50, paragraph 4–3b(10); or NGR 351–5, paragraph 2–29i, as appropriate, and will be reassigned in his or her original military occupational specialty (MOS) in accordance with assignment policies of chapters 4 or 5. Reassignment will be without regard to PCS restrictions.

3–4. Confidentiality

The provisions of chapters 2 and 7 with regard to confidentiality and use of information apply to this chapter, except that HIV infection may be used as the basis for separation under the accession testing program. Care will be taken that no one without a "need to know" in the performance of his or her duties is given any information about an applicant's HIV status.

Chapter 4
Active Duty Personnel Policies and Procedures

Section I
Assignment Policies and Procedures

4–1. General

a. The policies and procedures in this chapter apply to all AD soldiers including AGR personnel.

b. Individuals who are confirmed to be HIV -infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains.

c. Every effort will be made to ensure that, except for their assignment limitations, HIV-infected personnel are treated no differently than other soldiers. Commanders must ensure that information about the HIV-infected soldier's medical condition is provided only to those whose duties require knowledge of that information.

4–2. Assignment limitations

a. HIV-infected soldiers will not be deployed or assigned overseas. Soldiers confirmed to be HIV-infected while stationed overseas will be reassigned to the United States per paragraph 4–7b.

b. In the United States (including Alaska, Hawaii, and Puerto Rico), HIV-infected soldiers will not be assigned to—

(1) Any Table of Organization and Equipment (TOE) or Modified Table of Organization and Equipment (MTOE) unit. Installation commanders may reassign any HIV-infected soldier in such units to Table of Distribution and Allowances (TDA) units on their installation provided the soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment

to TDA units may be made provided assignment can be made according to normal personnel management and assignment criteria in AR 600–200, AR 614–100, and AR 614–200. Reassignment must be to an authorized position for the soldier's grade and PMOS or SMOS. Installation commanders unable to make appropriate reassignments will report the names of HIV-infected soldiers to Cdr, PERSCOM, ATTN: TAPC–EPS–C (enlisted) or TAPC–OPD–M (officer).

(2) Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV-infected soldiers assigned to these programs will be disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to PCS restrictions. Any financial support received by the soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military-sponsored educational programs will be waived. Not included in this restriction are military schools required for career progression in a soldier's MOS, branch, or functional area (such as, noncommissioned officer education system (NCOES) schools, officer advanced course, or Command and General Staff College).

(3) U.S. Army Recruiting Command (USAREC), Cadet Command, USMEPCOM, ARNG Full Time Recruiting Force (FTRF), or ARNG Full Time Attrition/Retention Force (FTARF) if a soldier's medical condition requires frequent medical follow-up (medical authorities will determine if follow-up is frequent) and the soldier's projected duty station is geographically isolated from an Army MTF capable of providing that follow-up. These organizations will report HIV-infected soldiers who cannot be assigned per this policy to Cdr, PERSCOM, ATTN: TAPC–EPS–C (enlisted) or TAPC–OPD–M (officer), for assignment instructions (AI). For special branch-managed officers, forward assignment requests to HQDA(DAJA–PT) for Judge Advocate General Corps (JAGC) officers, or HQDA(DACH–PEA) for chaplains. For ARNG AGR Title 10 personnel, all requests should be sent to Cdr, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450; for ARNG FTNGD Title 32 personnel, requests should be sent to the applicable State Adjutant General. Requests for AI for USAR AGR personnel should be sent to Cdr, ARPERCEN, ATTN: DARP–ARE–S, 9700 Page Blvd., St. Louis, MO 63132–5200.

c. Assignment preclusion from units, organizations, schools, or programs other than those listed above must be approved by HQDA(DAPE–HR).

d. Commanders may not change the assignment or utilization of HIV-infected soldiers solely because of their infection unless required by this regulation or the soldier's medical condition (as reflected on DA Form 3349 or other pertinent medical records). Grouping all HIV-infected soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available. HIV-infected health care providers may be restricted in the performance of their duties when the nature of those duties, as determined by an expert medical review committee, presents a risk of transmitting the virus to their patient. HIV-infected health care providers may be restricted in their duties only to the extent that they no longer present a risk of transmitting HIV to their patient.

e. HIV-infected service members may transfer to the Active Army from another Armed Force (inter-service transfer) if they meet medical retention standards (AR 40–501, Chap 3). However, service members who are HIV-infected may not be transferred to the Army from another Armed Force if they are required to meet accession medical standards (AR 40–501, chap 2), except as specifically permitted in chapter 3 of this regulation.

f. HIV-infected soldiers who demonstrate progressive clinical illness or immunological deficiency will be processed per section III of this chapter. (See the Glossary for definition of progressive clinical illness and immunological deficiency.)

4–3. Accompanied tours

a. Family members who are HIV-infected may accompany their sponsor overseas. Paragraph 6–12 provides guidance for processing HIV-infected family members.

b. When a family member is HIV-infected, the sponsor may request deletion from an overseas assignment alert based on compassionate reasons, or request an "all others" tour. Deletion of the sponsor from overseas assignment instructions is not mandated solely based on a family member's HIV antibody status. If assigned overseas at the time the family member is diagnosed as HIV-infected, the sponsor may apply for a curtailment of foreign service tour (FST) for compassionate reasons per AR 614–30, chapter 8. A mandatory PCS or curtailment of FST of the sponsor will not occur solely because a family member is determined to be HIV-infected.

4–4. Military schooling

Soldiers who are HIV-infected and are determined to be fit for duty are eligible for all military professional development schools (such as NCOES, officer advanced course, and Combined Arms and Services Staff School). HIV-infected soldiers may also attend formal military training required to qualify them for reclassification to a new MOS or award of a skill qualification identifier (SQI), additional skill identifier (ASI), skill, or functional area provided the schooling does not exceed 20 weeks.

4–5. Reenlistment

a. HIV-infected enlisted soldiers who meet medical retention standards of AR 40–501, chapter 3, are eligible to reenlist, if otherwise qualified.

b. There is no requirement to have an HIV test as part of reenlistment qualification unless the soldier desires to reenlist for an overseas duty assignment or for an organization cited in paragraph 4–2b. Soldiers will not be permitted to reenlist for an overseas duty assignment or an organization cited in paragraph 4–2b unless they have tested negative for the HIV antibody within the 6 month period preceding the desired date of reenlistment. If HIV-infected, they may reenlist for any option in AR 601–280 except overseas or restricted units, or military schools exceeding 20 weeks.

c. Enlisted soldiers who enlisted or reenlisted for a unit or organization cited in paragraph 4–2b and who subsequently are confirmed as HIV-infected will be processed as follows:

(1) If otherwise eligible, soldiers will be advised of the procedures of AR 635–200, paragraph 7–16b, concerning requests for separation due to unfulfilled enlistment commitments.

(2) Soldiers who are not eligible for separation under AR 635–200, paragraph 7–16, and who are not under a suspension of favorable personnel actions, may request separation for the convenience of the government under AR 635–200, paragraph 5–3. These procedures are outlined in paragraph 4–13.

(3) Enlistment contracts may be renegotiated where appropriate and soldiers, if otherwise eligible, may be given other options commensurate with the established assignment limitations for HIV-infected soldiers.

4–6. Utilization

There is no medical reason for HIV-infected soldiers' duties to be changed solely because of their infection (except in certain instances for health care providers). In instances where a soldier performs duties as a member of a flight crew or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination will be made by a medical evaluation board as to the soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted when performing those duties presents a risk of transmitting HIV to their patient. This determination will be made by an expert medical review committee. This committee will make recommendations on a case-by-case basis to the MEDDAC/MEDCEN/DENTAC commander per AR 40–68 as to the restriction of duties of HIV-infected health care providers. The restriction may only be to the extent that the risk is eliminated. In all other instances, HIV-infected soldiers will be utilized in their primary MOS per normal utilization criteria contained in Army personnel regulations and the assignment limitations in paragraphs 4–2b and 4–2d.

4–7. Assignment/reassignment policies and procedures

a. Overseas policies.

(1) Soldiers serving overseas who are identified as HIV-infected will have their FST curtailed and will be expeditiously reassigned to the United States. This paragraph does not apply to soldiers who are permanent residents of and are currently stationed in Guam, the Virgin Islands, or American Samoa. It does, however, apply to all soldiers not currently assigned to these locations. HIV-infected soldiers who are assigned outside these areas and who desire compassionate reassignment to these areas may apply per existing policies for compassionate reassignments. Requests will be considered on a case-by-case basis.

(2) Soldiers who are returned to the United States will have their FST curtailed per AR 614–30, chapter 8, and will be given credit for a completed tour as prescribed in AR 614–30, table 7–1.

(3) Overseas MACOM commanders are authorized to approve a second PCS in the same fiscal year for HIV-infected soldiers returning to the United States under this program. See AR 614–30, table 1–1.

b. Overseas procedures.

(1) Overseas adjutants general or personnel officers will, upon receipt of formal notification of soldiers who are HIV-infected, request immediate FST curtailment per AR 614–30, chapter 8 and table 1–1. Curtailments of FST will be coordinated by priority message (FOR OFFICIAL USE ONLY) with Commander, PERSCOM, ATTN: TAPC–EPS–C (enlisted) or TAPC–OPD–M (officer), for AI. For special branch-managed officers, forward assignment requests to HQDA(DAJA–PT) for JAGC officers, or HQDA(DACH–PEA) for chaplains. (For ARNG AGR Title 10 personnel, all requests should be sent to Commander, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450; for USAR AGR personnel, all requests should be sent to Commander, ARPERCEN, ATTN: DARP–ARE–S, 9700 Page Blvd., St. Louis, MO 63132–5200.) Requests will include the following:

(a) Name, grade, social security number, primary military occupational specialty (PMOS) or control branch, and unit of assignment.

(b) Include the statement: "This curtailment request is submitted per AR 600–110, paragraph 4–7b."

(c) Desired report date.

(d) Three assignment preferences in the United States (including Alaska, Hawaii, or Puerto Rico) with rationale from the soldier as to the three choices (for example, to be near family).

(e) Known assignment limitations or special considerations that should be considered in making the assignment.

(f) Tour type: accompanied, unaccompanied (family members in the United States), unaccompanied (family members in-country at sponsor's personal expense).

(2) Commander, PERSCOM (Commander, GuardPERCEN, ATTN: NGB–ARP–CT, for ARNG Title 10 AGR personnel, or Commander, ARPERCEN, ATTN: DARP–AR, for USAR AGR personnel) will issue AI expeditiously.

(3) Soldiers overseas identified for referral into the physical disability system will be expeditiously processed per AR 635–40.

(4) Nothing in the procedures discussed above should be interpreted as prohibiting a soldier from taking leave overseas solely because of HIV infection. Current Army and DoD policy does not restrict a soldier from any travel in a leave status based on the results of an HIV antibody test. However, HIV-infected soldiers must meet entrance requirements for countries they intend to visit. Countries may require evidence of HIV testing and may require negative test results as part of those entrance requirements.

c. CONUS policies.

(1) Soldiers identified as HIV-infected and who are assigned to organizations cited in paragraph 4–2b will be transferred within their current installation. If local reassignment is not possible, HIV-infected soldiers will be reported to Commander, PERSCOM for AI. These soldiers are eligible for other assignments in the United States (including Alaska, Hawaii, or Puerto Rico) according to the needs of the Army and existing PCS policies.

(2) Soldiers who receive overseas AI will require an HIV antibody test as part of their soldier reassignment processing requirements if they have not been tested in the 6 months prior to their port call. Those who are HIV-infected will be deleted from AI. Soldiers with a family member who is HIV-infected will follow the policies and procedures in paragraphs 4–3b and 6–12.

d. CONUS procedures.

(1) Adjutants general/personnel officers in the United States will, upon receipt of formal notification from the commander of the local MTF of soldiers who are HIV-infected, take the following actions :

(a) For enlisted personnel, submit into SIDPERS Assignment Eligibility and Availability (AEA) Code B without a termination date. No other AEA Code (such as Code U for reenlistment stabilization) will be used later to overlay the AEA Code B.

(b) Soldiers who are HIV-infected will be deleted from overseas AI. For enlisted personnel, requests for deletions will be submitted to Commander, PERSCOM, ATTN: TAPC–EPS–C. Approval will be automatic and confirmed through the Enlisted Distribution Assignment System (EDAS) by PERSCOM. For officer personnel, requests for deletions will be forwarded to Commander, PERSCOM, ATTN: TAPC–OPD–M (for Officer Personnel Management Directorate (OPMD)-managed officers); HQDA(DAJA–PT) for JAGC officers; or HQDA(DACH–PEA) for chaplains. For ARNG Title 10 AGR personnel, all requests for deletion will be forwarded to Commander, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450; for ARNG Title 32 AGR personnel, all requests for deletion will be forwarded to the State Adjutant General, ATTN: Support Personnel Management Office (SPMO), of the particular State/territory to which the AGR soldier is assigned for duty. For USAR AGR personnel, all requests for deletion will be forwarded to Commander, ARPERCEN, ATTN: DARP–ARE–S.

(c) Other than accession testing per chapter 3 of this regulation, soldiers undergoing initial entry training (to include PS soldiers) with AI to an overseas location and who are confirmed as HIV-infected will be reported to Commander, PERSCOM, ATTN: TAPC–EPO–O under provisions of AR 612–201 for deletion and issuance of AI to an installation in the United States or Puerto Rico.

4–8. Transfer of personnel and medical records

The procedures below apply to the transfer of personnel and medical records of all soldiers identified as HIV-infected. These procedures apply to moves within the United States as well as from overseas locations to the United States, excluding those conducted through the medical evacuation channels.

a. Losing installation commanders will ensure that the gaining installation/unit's medical and personnel POCs are aware of an incoming/arriving HIV-infected soldier.

b. When AI on an HIV-infected soldier are received, the losing PSC HIV POC will contact the local HIV program POC and provide the expected date of departure, the new assignment location/unit, and the anticipated arrival date. The local HIV program POC will notify the HIV program POC at the gaining installation of the soldier's expected date of departure from the current installation, the anticipated arrival date at the gaining installation, and the new assignment location/unit. The gaining HIV program POC will, in turn, notify the gaining PSC HIV POC of the soldier's pending arrival. Once the soldier has reported to his or her new unit, the gaining HIV program POC will notify the soldier's unit commander of the soldier's HIV status.

c. The losing HIV program POC will ensure that copies of medical records pertaining to the patient's diagnosis and evaluation of the HIV infection are forwarded to the gaining HIV program POC in advance of the patient's arrival.

(1) Care will be taken to protect the confidentiality of the records by sealing them in an envelope marked "'Sensitive Medical Records—To Be Opened By Addressee Only", then inserting the envelope into a carrier addressed directly to the attention of the receiving HIV program POC, by name when known.

(2) Records will be mailed using a return receipt type delivery method.

(3) Upon clearing the local MTF, the soldier will be allowed to hand carry the original outpatient treatment records and copies of any pertinent inpatient treatment records sealed in an envelope with the name, location, and telephone number of the gaining HIV program POC. Terms that might identify the soldier's condition will not be used on this envelope.

(4) There is no requirement to forward copies of medical records not related to the HIV infection.

(5) The soldier will be instructed to establish contact with the gaining HIV program POC immediately upon arrival at the new location.

d. Soldiers who are returning to the United States from overseas for staging will be ordered as part of PERSCOM (ARPERCEN (DARP–ARE–S) for USAR AGR soldiers) AI to report TDY en route to the designated Army MEDCEN for the new assignment location for a period not to exceed 15 days. PERSCOM will ensure that the AI include instructions to provide a copy of the PCS orders to the designated MEDCEN. Soldiers who will be accompanied by family members will be counseled that housing for the family at the TDY location will be at the soldier's own expense and that government transient quarters may not be available. Soldiers referred to medical/physical evaluation boards immediately following staging will be handled per normal medical holding unit procedures and will be deleted from their original orders. The MEDCEN HIV POC will telephonically notify the gaining installation HIV program POC when this occurs.

e. Upon completion of staging, the HIV POC at the MEDCEN will notify the receiving unit/installation HIV program POC of staging.

f. The gaining HIV program POC will ensure that any immediately necessary medical care, to include staging or restaging, is fully coordinated. The HIV program POC will notify the gaining unit commander of the soldier's medical condition as soon after the patient's arrival as possible.

g. HIV-infected soldiers transferred into a unit will be provided preventive medicine counseling and commander's counseling in the same manner as that prescribed for newly identified HIV-infected soldiers. (See para 2–13 and 2–14.)

4–9. Monitoring patient health

a. Long term monitoring of the patient's health is essential. Complete restaging will be accomplished annually; t-cell subset evaluation will be done at least every six months. Commanders should be advised if AD patients fail to comply with treatment instructions, preventive medicine counseling, or orders given during the commander's counseling. Disease progression must be monitored closely and updates provided promptly to USAHDS for data base inclusion.

b. Attending physicians/medical POCs must inform the patient's commander when a significant change in immunological status or clinical disease status is identified. Likewise, commanders must consult the attending physician/medical POC if the soldier's fitness for duty becomes suspect. Soldiers thought to be unfit for duty will be processed through normal medical/physical evaluation boards for determinations.

c. When HIV-infected soldiers are attached to another unit for a period in excess of 15 days, their commanders will personally notify the gaining unit commander of the soldier's medical condition. The gaining commander will maintain this information confidentially and will release that information only to those with an established need to know of the medical condition.

Section II
Procedures

4–10. Overseas

a. The medical activity commander/division surgeon—

(1) Provides formal notification to the unit commander and the adjutant general/personnel officer having custody of an HIV-infected soldier's Military Personnel Records Jacket (MPRJ).

(2) Schedules HIV-infected soldiers for further medical staging and evaluation at the designated regional MEDCEN.

b. The adjutant general/personnel officer having custody of the MPRJ of HIV-infected soldiers —

(1) Requests FST curtailment per AR 614–30, chapter 8.

(2) Expeditiously processes AI issued by PERSCOM (GuardPERCEN or ARPERCEN for AGR personnel) and issue necessary orders.

(3) Follows procedures prescribed in paragraph 4–7b.

c. The Commanding General, PERSCOM —

(1) Issues AI for soldiers identified as HIV-infected.

(2) Directs award of tour credit in the special instructions of the AI.

d. For AGR personnel, the Commander, GuardPERCEN, or the Commander, ARPERCEN will have the procedures described for CG, PERSCOM, in c above.

4–11. CONUS

a. The HIV program director —

(1) Provides formal notification to the unit commander and the adjutant general/personnel officer having custody of the MPRJ of HIV-infected soldiers.

(2) Ensures that soldiers are referred into the physical disability system, as appropriate.

b. Adjutants general/personnel officers having custody of the MPRJ of HIV-infected soldiers —

(1) Requests deletion of those soldiers who are on overseas AI.

(2) Reassigns locally those soldiers who are infected and are assigned to organizations cited in paragraph 4–2b. Requests AI in those cases where on-post transfer cannot be accomplished to satisfy assignment policy limitations.

(3) Follows the procedures described in paragraph 4–7d.

c. The CG, PERSCOM —

(1) Approves deletion requests for HIV-infected soldiers who are on overseas AI.

(2) Upon request, issues AI for those soldiers in organizations cited in paragraph 4–2b who cannot be reassigned locally.

d. For AGR personnel, the following individuals will perform those procedures described for CG, PERSCOM, in paragraph c above.

(1) The Commander, GuardPERCEN, for ARNG personnel on NGB-controlled Title 10 tours.

(2) The State Adjutants General, for ARNG personnel on Title 32 tours.

(3) The Commander, ARPERCEN (DARP–AR), for all USAR personnel.

Section III
Administrative Separations

4–12. Administrative separation of officers

a. Officers who are HIV-infected and no longer desire to remain on AD may submit an unqualified resignation under the provisions of AR 635–120, chapter 3 (RA and other than Regular Army (OTRA) officers), or request voluntary REFRAD under the provisions of AR 635–100, chapter 3, section IX (OTRA officers only), as appropriate. Probationary officers (as defined in AR 635–100, para 5–30) who have tested positive for HIV infection and who were infected prior to acceptance of appointment may request resignation under the provisions of AR 635–120, chapter 14.

b. Officers submitting voluntary applications for resignation or REFRAD should use the formats indicated in AR 635–120 or AR 635–100, as appropriate. The request will cite paragraph 4–12a as the basis. The officer will execute the following statement and include it in his or her application: "I have been counseled by a member of The Judge Advocate General's Corps regarding the consequences of my request and I certify that this request is voluntary. I understand that if my request is accepted, I will be granted an honorable discharge (if requesting resignation)or honorable characterization of service (if requesting REFRAD)." Officers who are HIV-infected but still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General's Corps who will explain the impact of the officer's request. As a minimum, specific information regarding the officer's post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum:"Officer was advised that disability benefits under provisions of Chapter 61, Title 10, U.S. Code, may be available in the event that he/she remains in the Army until the U.S. Army Physical Disability Agency determines the officer is no longer fit to perform assigned military duties."

c. Requests for resignation or REFRAD will be submitted through command channels to the appropriate career manager indicated below:

(1) Combat arms: Commander, PERSCOM, ATTN: TAPC–OPE–P, ALEX VA 22332–0414.

(2) Combat support arms: Commander, PERSCOM, ATTN: TAPC–OPF–P, ALEX VA 22332–0415.

(3) Combat service support: Commander, PERSCOM, ATTN: TAPC–OPG–P, ALEX VA 22332–0416.

(4) Functional area: Commander, PERSCOM, ATTN: TAPC–OPB–A, ALEX VA 22332–0411.

(5) Health services: Commander, PERSCOM, ATTN: TAPC–OPH–P, ALEX VA 22332–0417.

(6) Colonels: Commander, PERSCOM, ATTN: TAPC–OPC–A, ALEX VA 22332–0412.

(7) Warrant officers: Commander, PERSCOM, ATTN: TAPC–OPW–P, ALEX VA 22332–0420.

(8) Chaplains: HQDA(DACH–PER), WASH DC 20310–2700.

(9) JAGC officers: HQDA(DAJA–PT), WASH DC 20310–2200.

(10) AGR Officers: For ARNG Title 10 AGR officers, Commander, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450; for ARNG Title 32 AGR officers, State Adjutant General, ATTN: SPMO. For USAR AGR officers, Commander, ARPERCEN, ATTN: DARP–ARE–S, 9700 Page Blvd, St. Louis, MO 63132–5200.

d. RA commissioned and warrant probationary officers entering AD who are identified as HIV –infected within 180 days of their original appointment, or USAR and ARNG commissioned and warrant probationary officers who report for initial entry training in an AD (other than ADT) status and are identified as HIV-infected within 180 days of reporting to AD, will be processed for discharge under the provisions of AR 635–100, chapter 5, section IX.

e. Officers who are HIV-infected and have been found not to have complied with preventive medicine counseling

prescribed in paragraph 2–13 may be involuntarily discharged. Commanders may recommend that such officers be eliminated under the provisions of AR 635–100, chapter 5. Recommendations for separation must be based upon information obtained independently from interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that an officer is HIV-infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

f. Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the ADAPCP, or the routine diagnosis of sexually transmitted diseases other than HIV.

g. HIV-infected officers remain subject to involuntary separation under any provision of AR 635–100 or AR 635–120, as appropriate. The policies described in chapter 7 of this regulation apply. Officers who no longer meet medical retention standards will be processed per AR 635–40.

4–13. Administrative separation of enlisted personnel

a. Enlisted soldiers who are HIV-infected may submit a voluntary request for discharge under the provisions of AR 635–200, paragraph 5–3. Voluntary requests for separation will be submitted through command channels to Commander, PERSCOM, ATTN: TAPC–PDT–S, ALEX VA 22331–0479. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450. GuardPERCEN will forward these requests to PERSCOM for decision. Requests from ARNG Title 32 enlisted AGR personnel will be sent to the State Adjutant General, ATTN: SPMO, of the particular State/territory in which the soldier is assigned for duty. For USAR AGR enlisted personnel, requests will be sent to Commander, ARPERCEN, ATTN: DARP–ARE–S, 9700 Page Blvd., St. Louis, MO 63132–5200 for forwarding to PERSCOM.) Requests for voluntary separation will not be accepted from soldiers who no longer meet medical retention standards of AR 40–501. Such soldiers will be processed for medical separation under the provisions of AR 635–40.

(1) HIV-infected soldiers who still meet medical retention standards and desire to be discharged must be counseled by a member of The Judge Advocate General's Corps who will explain the impact of the soldier's request. As a minimum, specific information regarding the soldier's post-discharge eligibility for medical care will be provided. A copy of the counseling statement will accompany the request for separation. The counseling statement will contain the following statement, as a minimum:"Soldier was advised that disability benefits under provisions of Chapter 61, Title 10, U.S.Code, may be available in the event that he/she remains in the Army until the U.S. Army Physical Disability Agency determines the soldier is no longer fit to perform assigned military duties."

(2) Soldiers desiring discharge will complete a DA Form 4187 (Personnel Action) and execute the following statement: "I request discharge from the Army under the provisions of AR 635–200, paragraph 5–3, for my own convenience. I have been counseled by a member of The Judge Advocate General's Corps regarding the consequences of my request, and I certify that this request is voluntary. I understand that, if my request is accepted, I will be granted an honorable discharge."

(3) Requests for separation must include certification that the soldier is HIV-infected but meets medical retention standards. Commanders endorsing requests for separation under the provisions of a above will verify the soldier's medical condition and that the soldier still meets medical retention standards.

b. Soldiers identified as HIV-infected within 180 days of initial entry on AD will be separated under the provisions of AR 635–200, paragraph 5–11.

c. HIV-infected enlisted soldiers found not to have complied with preventive medicine counseling prescribed in paragraph 2–13 may be involuntarily separated. Commanders may recommend that such enlisted soldiers be separated under the provisions of AR 635–200, paragraph 5–3; chapter 14, section III; or chapter 15, as the unit commander deems appropriate. The following procedures apply:

(1) If the soldier is processed for separation under the provisions of AR 635–200, paragraph 5–3, the notification procedure (AR 635–200, chap 2, sec II) will be used to notify the soldier that his or her discharge is being recommended. Soldiers processed for separation under the provisions of AR 635–200, chap 14, will be notified of the recommendation for discharge under administrative board procedures (AR 635–200, chapter 2, sec III) or the notification procedure (AR 635–200, chapter 2, section II), as appropriate. Soldiers processed for separation under the provisions of AR 635–200, chapter 15, will be notified under the administrative board procedures.

(2) Recommendations for involuntary separation must be based upon information that is not obtained through interviews or surveys conducted in conjunction with the epidemiologic assessment process. Other than the fact that a soldier is HIV-infected and has been counseled regarding preventive medicine procedures, no other information related to the assessment process will be used to support involuntary separation. Evidence of unprotected intimate sexual behavior, drug abuse, or other violations of the preventive medicine procedures must be derived from sources not related to the assessment process.

(3) Examples of independently derived evidence include, but are not limited to, urinalysis tests conducted under the ADAPCP, or the routine diagnosis of sexually transmitted diseases other than HIV.

(4) Recommendations for involuntary separation under the provisions of AR 635–200, paragraph 5–3, and recommendations for involuntary separation of soldiers with 18 or more years of service will be forwarded to Commander, PERSCOM, ATTN: TAPC–PDT–S, for processing. (For ARNG Title 10 enlisted AGR personnel, requests will be sent to Commander, GuardPERCEN, ATTN: NGB–ARP–CT, 4501 Ford Ave., Alexandria, VA 22302–1450; for ARNG Title 32 enlisted AGR personnel, requests will be sent to the State Adjutant General, ATTN: SPMO, of the particular State/territory in which the soldier is assigned for duty. For USAR enlisted AGR personnel, requests will be sent to Commander, ARPERCEN, ATTN: DARP–ARE–S, 9700 Page Blvd., St. Louis, MO 63132–5200.) As a minimum, recommendations for separation must include documentation of the notification process (to include the soldier's acknowledgement of notification), statements submitted by the soldier and/or his or her counsel, certification that the soldier has been counseled regarding preventive medicine measures, and details/evidence of the soldier's failure to comply with those measures.

d. HIV-infected enlisted soldiers remain subject to involuntary administrative separation under any provision of AR 635–200; however, soldiers who no longer meet medical retention standards will not be involuntarily separated except under AR 635–200, chapter 3, section IV; chapter 10; chapter 14 (see AR 635–200, para 1–35b for limitations); chapter 7,section V (see AR 635–200, para 1–35b for limitations); chapter 15; and paragraph 5–3.

4–14. Disability separation

a. HIV-infected military personnel who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, do not meet medical retention standards of AR 40–501 and may be processed for separation per AR 40–501 and AR 635–40.

b. While clinical staging will not serve as the criterion for determining medical fitness or a disability rating, the clinical manifestations that determine a stage of the disease may, in fact, contribute to determining a soldier's fitness for duty. All HIV-infected soldiers who show signs of immunological deficiency or a progressive illness must be referred to medical evaluation boards regardless of the clinical stage of the disease. This should result in a more expeditious status determination that will benefit both the patient and the government.

Chapter 5
ARNG and USAR Personnel Policies and Procedures

Section I
General

5–1. Introduction

This chapter prescribes policies and procedures pertaining to the ARNG and the USAR. These policies and procedures are intended primarily to apply to TPU; however, the policies and procedures also pertain to the IRR and IMA.

5–2. Testing requirement for active duty personnel

a. Personnel ordered to AD for a period of more than 30 days including travel time (for example, ADT, AGR, initial active duty for training (IADT), temporary tours of active duty (TTAD), and active duty for special work (ADSW)) must have been tested for HIV antibodies with negative results within the 6 months prior to the report date and prior to issuance of orders. In rare situations where this requirement cannot be met, orders will include the following statement: "You will obtain an HIV antibody test from a designated military facility en route to, or immediately upon, arrival at your duty station. If you are HIV antibody positive, or HIV antibody negative results are not communicated through established medical channels to the orders issuing authority within the first 29 days including travel time, these orders will terminate."

b. Under mobilization conditions (as declared by Congress or Executive Order and implemented by DoD), the ASA(M&RA) may authorize HIV-infected RC soldiers to be order to EAD. If ordered to EAD, RC soldiers known to be HIV-infected and those who are identified as HIV-infected during mobilization station testing will be assigned and utilized within the United States (including Alaska, Hawaii, and Puerto Rico).

Section II
ARNG Policies and Procedures

5–3. General

a. HIV testing and retention policies will be consistent with all DOD and DA policies and regulations. Medical unit mission training requirements preclude the use of ARNG medical units to conduct HIV screening except as part of required periodic physical examinations.

b. In order to voluntarily transfer from one RC to another, or to voluntarily transfer to the IRR, ARNG soldiers must

have been tested for HIV with negative results no longer than 5 years prior to the date of transfer. This does not apply to HIV-infected soldiers exercising their option to voluntarily transfer to the Standby or Retired Reserve.

5–4. Overview of the ARNG HIV testing program

The ARNG HIV testing program is accomplished primarily during periodic physical examinations and will be conducted every 5 years. The HIV testing program includes:

a. Testing of all nonprior and prior service accessions per chapter 3.

b. Testing of AGR soldiers and ARNG soldiers on EAD will be accomplished per Active Army policy prescribed in chapter 4.

c. Testing of active drilling soldiers of ARNG units.

d. Testing of all personnel who transfer from another Service or USAR control group into the ARNG, including members of the Inactive National Guard (ING).

5–5. Priority for testing

a. Soldiers who are scheduled for overseas PCS will be tested prior to PCS.

b. Testing will be based on the priorities listed in paragraphs 2–2h and *i*.

5–6. Medical support for testing

a. All medical support for HIV antibody testing will be per chapter 2.

b. To ensure maximum participation with minimal interruption of mission training, States will identify testing locations by month, date, and quantities of blood samples to be submitted according to the testing contract. The minimum number of testing sites necessary to accomplish the mission will be utilized in order to reduce the overall cost of the contract.

c. Blood samples will be drawn per the current ARNG national contract and instructions published by NGB.

d. Transmittal sheets matching names, SSNs, and units with laboratory numbers will be maintained by each State HIV POC. All transmittal sheets will be confidentially handled as medical records.

e. Soldiers who are initial Western Blot positive will be contacted and notified of the results of the initial test. A new blood sample will be drawn and tested. If the results of the second Western Blot test are negative, a third test will be performed on a fresh specimen. If the results of either the second or third Western Blot test are positive, the soldier will be notified and counseled per paragraph 5–8. The soldier's spouse will be notified of the positive test results per procedures published by NGB.

5–7. Procedures

a. The CNGB is responsible for implementation of HIV testing of ARNG members every 5 years.

b. State Adjutants General —

(1) Develops State testing plans. Plans will include notification and counseling of HIV-infected soldiers, reporting and recording of testing data, and procedures for periodic followup of ARNG soldiers who are AGR or on EAD and are HIV-infected. States will appoint a State POC for coordination of the HIV testing program.

(2) Ensures medical patient confidentiality is maintained per laws and regulations and specifically ensure that there are no unwarranted disclosures of information concerning an individual's medical condition.

c. State POCs will be responsible for coordination with unit commanders, the State surgeon, the NGB POC, and the contractor per NGB instructions.

d. The contractor will ensure that blood specimens are obtained from the correct soldier, properly labeled, and secured per the ARNG contract.

e. Unit commanders will ensure that all personnel in their units are tested and that HIV infection/AIDS information and education is included in unit training programs per chapter 8.

5–8. Notification and counseling

a. The results from testing will be returned by the contractor to the State POC. The State surgeon will be notified of any soldier whose initial test cycle is HIV antibody positive so that followup can be conducted. Initial test cycle Western Blot positive soldiers will be individually and privately notified of results by designated medical corps officers within the States. Negative HIV test results will be mailed to soldiers on DA Form 5668, which is available through normal publications channels. The DA Form 5668 may be signed by the State HIV POC (or designee) in lieu of a medical authority. Spouses of confirmed HIV-infected ARNG soldiers will be notified of the positive test results per procedures published by NGB.

b. HIV-infected ARNG soldiers, not AGR or on EAD, and their spouses will be counseled regarding the significance of a positive HIV antibody test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. Counseling of ARNG soldiers will be conducted per paragraphs 2–13 and 2–14. HIV-infected ARNG soldiers will be referred to civilian physicians for medical care and further counseling. The telephone number of local

civilian health authorities will be given to soldiers if information on local physicians or facilities is requested. Paragraph 6–9 provides guidance for offering HIV testing and counseling to spouses of HIV-infected ARNG soldiers.

c. Individuals tested at MEPS for accession purposes or component transfers will be notified of HIV antibody positive test results by the examining physician or other appointed, qualified counselor. Soldiers tested at MEPs as part of a periodic physical examination (space available basis) will be notified of HIV antibody positive test results through the soldier's unit physician or chain of command.

d. The soldier, commander, and medical corps officer will be in official status (inactive duty training (IDT), Reserve Special Training, ADT, AT, or ADSW) at the time of notification(s), counseling, and blood drawing.

5–9. Reporting and recording of information

a. Recording of the results of HIV testing will be per chapter 2, section IV.

b. Collection procedures and reporting of information for inclusion in the DOD data base will be per chapter 2, section IV.

c. Notification to commanders of results of Western Blot testing will be per paragraph 2–11.

d. Notification to public health authorities will be per procedures published by NGB and per state and local law.

5–10. Assignment and personnel actions

Soldiers confirmed to be HIV-infected, but who manifest no evidence of progressive clinical illness or immunological deficiency, will not be separated solely on the basis of their HIV infection. The following policies apply:

a. HIV-infected soldiers, not AGR or on EAD, may prove fitness for service. ARNG HIV-infected soldiers will have 120 days from the date they are notified of their infection to complete a medical evaluation to determine fitness per the established DOD protocol for HIV or other guidance published by OTSG. HIV-infected ARNG soldiers found to be medically unfit for duty will be separated per paragraph 5–11. Soldiers found fit will be permitted to serve in the Selected Reserve in a nondeployable billet, if available. Grade, MOS, and commuting constraints are applicable per existing regulations. Soldiers meeting fitness standards and placed in nondeployable billets must be reevaluated at least annually. Initial and subsequent evaluations will be at the soldier's expense and will be processed per instructions published by NGB. ARNG soldiers may request transfer to the Standby Reserve, Retired Reserve (if eligible), or honorable discharge under the plenary authority of the Secretary of the Army in lieu of continued service (AR 135–175, para 6–9, or AR 135–178, para 4–4). HIV-infected ARNG soldiers will be involuntarily transferred to the Standby Reserve, following a case-by-case assessment, if they—

(1) Fail to complete the initial medical evaluation in the prescribed period; or

(2) Are found fit, but cannot be placed in a Selected Reserve nondeployable billet per grade/MOS/ commuting constraints; or

(3) Are in a Selected Reserve nondeployable billet and do not complete the annual reevaluation.

b. The mere fact of HIV infection, in and of itself, will not be used as the basis for—

(1) Disciplinary action against the individual under the UCMJ or State Code.

(2) Adverse characterization of service.

(3) Non-selection for a vacant nondeployable billet.

c. Unit commanders who initiate action to transfer HIV-infected soldiers to the USAR Control Group (Standby) will do so under the provisions of NGR 600–200 or NGR 635–100, as appropriate.

d. Assignment and retention policies for ARNG soldiers who are AGR or on EAD and are HIV-infected will be carried out per chapter 4.

e. HIV-infected ARNG soldiers will not be ordered to a tour of duty for more than 30 days, nor extended on a tour of duty if the extension will cause the total length to exceed 30 days except under mobilization conditions and as authorized by the ASA(M&RA) (see para 5–2b).

5–11. Separation procedures

HIV-infected ARNG soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, do not meet medical retention standards under AR 40–501 and will be processed in accordance with AR 635–40 and NGR 600–200 or NGR 635–101, as appropriate.

Section III
USAR Policies and Procedures

5–12. General

a. HIV testing and retention policies will be consistent with all DoD and DA policies and regulations.

b. All members of the USAR, not on active duty will be tested for the HIV antibody every 5 years. HIV testing will be performed as part of all periodic physical examinations, in accordance with AR 40–501, and more frequently if required by paragraphs 2–2k(3) and 2-2k(4) of this regulation.

c. HIV-infected soldiers will not be permitted to serve in the IRR. Those in the USAR when identified will be

processed per paragraph 5–17. HIV-infected active duty soldiers leaving active duty who have a contractual or statutory obligation remaining will be transferred to the USAR Control Group (Standby).

5–13. Procedures

a. The commanders of Forces Command, U.S. Army Pacific, and U.S. Army Europe and Seventh Army are responsible for the implementation of periodic HIV testing of USAR TPU members and will assist ARPERCEN in the HIV testing of its soldiers, especially with the positive notification phase.

b. Commander, ARPERCEN is responsible for implementation of periodic HIV testing of USAR IRR members. He will coordinate with MACOMs and chiefs of agencies for the testing of IMAs and will ensure compliance with the provisions of paragraphs 2–2k(3) and (4). Soldiers on ADT orders for 30 days or less will report to the active duty MTF located at or close to their ADT duty station for an HIV antibody test if their last HIV test is older than 48 months. Directors of Reserve Component Support (DRC) will assist soldiers when reporting for AD by coordinating HIV testing and notification of HIV infection as necessary.

c. Testing of AGR/EAD soldiers will be accomplished per the policies for AD soldiers in chapter 4 of this regulation.

5–14. Conduct of HIV testing

a. Personnel scheduled for AD for a period of more than 30 days are tested per paragraph 2–2i.

b. IRR and IMA USAR soldiers not on active duty who require testing or are participating in overseas deployment for training (ODT) will be tested in HSC facilities. Those IRR and IMA soldiers who require periodic medical examinations will be tested in HSC facilities and by Reserve medical units that perform physicals and have the capability to perform testing.

c. For USAR soldiers, annotate HIV test results on SF 88 (Report of Medical Examination), Item 50, if testing occurred as part of a physical exam. If testing occurred separately from a physical exam, annotate results on SF 600. Both SF 88 and SF 600 will be posted in the soldiers' medical records.

5–15. Notification and counseling

a. All USAR soldiers, including IRR, whose initial Western Blot HIV antibody test is positive will be notified of the results by a physician. USAR TPU soldiers tested at MEPS as part of a periodic physical examination will be notified of positive test results through their unit physician or chain of command. The ARPERCEN HIV POC will coordinate with the USARC for a physician to notify IRR/IMA initial Western Blot HIV antibody positive soldiers. Training and information packets will be provided by the USARC POC. Spouses of confirmed HIV-infected USAR soldiers will be notified of the positive test results per procedures published by OCAR.

b. HIV-infected USAR soldiers, not on EAD, will be counseled regarding the significance of a positive HIV antibody test, current medical knowledge on HIV infections, and ways to prevent transmission of the virus. They will be referred to civilian health care providers for medical care and further counseling. Paragraph 6–9 provides guidance for offering HIV testing and counseling to spouses of HIV-infected USAR soldiers.

c. All of the information contained in paragraph 2–13 and on DA Form 5669-R will be covered and copies of the record will be provided to the individual and commander (or designated commander's representative, if the commander is a general officer) at the time of notification. The counselor's copy will be forwarded through HIV Program POC (command) channels to the USARC POC. The USARC POC will forward the copy to the PMP of the servicing MTF to facilitate notification of public health officials. Notification to public health authorities will be per procedures published by OCAR and per State and local law. All records will be forwarded in a sealed envelope marked "To Be Opened By Addressee Only," via command channels addressed specifically to the USARC HIV Program POC by name.

d. Physicians performing notification and soldiers notified of an initial or subsequent positive Western Blot HIV antibody test will be in official status (IDT, Reserve special training, ADT, AT, ADSW) at the time of notification. ARPERCEN will use a "points only" format for its soldiers.

e. The unit commander of the initial Western Blot HIV antibody positive USAR TPU soldier will be immediately available at the time the soldier is notified by the physician. Immediately following the preventive medicine counseling, the commander will counsel the soldier per paragraph 2–14 and complete DA Form 4856 as shown in figure 2–3. The counseling statement will be destroyed if the soldier is determined to be uninfected.

5–16. Education

USAR unit commanders will ensure that the HIV infection/AIDS information and education requirements in chapter 8 are included in unit training programs. This training will be conducted annually and will be documented in command training records. Commanders are encouraged to use TDA AMEDD officers, mission and funds permitting. If AMEDD officers cannot be used, trainers may be members of the chain of command, assigned officers or enlisted soldiers, or nonmilitary personnel from outside sources.

5–17. Transfer from the Ready Reserve

a. USAR soldiers who are not AGR or EAD and are confirmed to be HIV-infected by a second or subsequent Western Blot test conducted per paragraph 2–5d may prove fitness for service. USAR HIV-infected soldiers will have 120 days from the date they are notified of their infection to complete a medical evaluation to determine fitness per instructions published by OCAR. HIV-infected soldiers will be provided a copy of the instructions during the preventive medicine counseling required in paragraph 5–15b. HIV-infected USAR soldiers determined to be medically unfit for duty will be separated per paragraph 5–18. Soldiers found fit will be permitted to serve in the Selected Reserve in a nondeployable billet, if available. Grade, MOS, and commuting constraints are applicable per existing regulations. HIV-infected USAR soldiers will be advised of the existence of any non-deployable billets during the commander's counseling required in paragraph 5–15e. Soldiers meeting fitness standards and placed in Selected Reserve nondeployable billets must be reevaluated at least annually per OCAR instructions. Initial and subsequent evaluations will be at the soldier's expense and will be processed per OCAR instructions. HIV-infected USAR soldiers may request transfer to the Standby Reserve, Retired Reserve (if eligible), or honorable discharge under the plenary authority of the Secretary of the Army in lieu of continued service (AR 135–175, para 6–9, or AR 135–178, para 4–4 and 4–7.1). HIV-infected USAR soldiers will be involuntarily transferred to the Standby Reserve, following a case-by-case assessment, if they—

(1) Fail to complete the initial medical evaluation in the prescribed period; or

(2) Cannot be placed in a Selected Reserve nondeployable billet per grade/MOS/commuting constraints; or

(3) Are placed in a Selected Reserve nondeployable billet and do not complete the annual reevaluation per OCAR instructions.

b. Unit commanders who initiate action to transfer HIV-infected soldiers to the USAR Control Group (Standby) will do so under the provisions of AR 140–10.

c. All HIV testing results and subsequent medical and personnel records related to notification, counseling, and transfer of HIV-infected soldiers are to be handled in a confidential manner per chapter 2, section IV.

d. In order to voluntarily transfer from one RC to another, or to voluntarily transfer to the IRR, USAR soldiers must have been tested for HIV with negative results not more than 5 years prior to the date of transfer. This does not apply to HIV-infected soldiers exercising their option to voluntarily transfer to the Standby or Retired Reserve.

5–18. Separation procedures

HIV-infected USAR soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, do not meet medical retention standards under AR 40–501 and will be processed per AR 135–178 (enlisted) or AR 135–175 (officer).

Chapter 6
Family Member and Civilian Personnel Policies and Procedures

Section I
HIV Testing for Family Members and Other Health Care Beneficiaries

6–1. Testing of family members and other HCBs

Family members and other HCBs may not be compelled to have an HIV test. However, an HIV test may be ordered by a physician as part of clinically indicated laboratory tests required to adequately treat the patient. Patients should be routinely informed that the physician will order any clinically indicated laboratory tests necessary to include testing for HIV infection unless the patient specifically declines such tests.

6–2. HIV testing program components

An HIV test may be clinically indicated for family members and other non-military health care beneficiaries seeking medical care under the circumstances listed below. Those who test HIV antibody positive will be offered medical evaluation and counseling per paragraphs 2–12 and 2–13.

a. Blood donor testing. All blood donations on military installations will be screened for the HIV antibody. Individuals who refuse to give consent for the testing will not be permitted to donate blood.

b. Suspicious illnesses. HCBs exhibiting signs and/or symptoms compatible with, or suggesting HIV infection, such as lymphadenopathy (enlarged lymph nodes), unexplained lymphopenia or leukopenia (depressed white cell count), neurological disease, adult oral candidiasis (thrush), or evidence of opportunistic infections (such as pneumocystis pneumonia or candida esophagitis) will be clinically indicative for HIV testing. HCBs may be tested in either the outpatient or inpatient setting as part of the medical evaluation.

c. Patients with sexually transmitted diseases (STD). These patients are seen mainly in STD, OB-GYN, urology, or dermatology clinics, but may be seen in any MTF clinic or ward. Each new STD infection, to include gonorrhea, non-

specific urethritis, syphilis, chancroid, lymphogranuloma venereum, granuloma inguinale, genital herpes, and sexually transmitted hepatitis B, should be considered clinically indicative that an HIV antibody test is warranted. This test should be followed by 3- to 6- and 12-month followup tests if the initial HIV test is negative. Such procedures are necessary to detect seroconversion in latent infections.

d. Blood transfusion/blood product recipients. The policies of the Armed Services Blood Program and guidelines of the FDA will be followed in the DA Blood Program and by civilian blood agencies collecting blood on Army installations.

(1) Persons who received blood transfusions or blood products after 1 January 1978 and prior to 1 July 1985 (the date routine HIV antibody screening of blood products began) will be identified, contacted, and encouraged to be tested for the presence of the HIV antibody.

(2) Blood or blood product donors whose donation tests positive for the HIV antibody will be notified and, if an HCB, counseled and evaluated as prescribed in this regulation.

(3) Recipients of blood products obtained from donors who are later determined to be HIV-infected will be located and notified of the potential risk, and encouraged to be tested and evaluated.

(4) Donors of blood or blood products whose donations were transfused to recipients who were later determined to be HIV-infected will be located, notified of their potential infection, and, if an HCB, will be offered testing and counseling.

e. Sexual partners.

(1) HIV testing is warranted when HCBs are, or have been, sexual partners of HIV-infected individuals. Although there are no documented cases of casual transmission of infection, other household members who are not sexual partners will be offered testing if there is any anxiety over the potential for household or casual transmission.

(2) When information is obtained through epidemiological assessment interviews indicating that individuals who are not military HCBs are, or have been, sexual partners of HIV-infected individuals, military preventive medicine authorities will report that information to civilian public health authorities. Reporting will be per local jurisdiction reporting requirements and HQDA policy.

f. Intravenous (IV) drug use. HCBs known, or suspected, to have used drugs intravenously will be advised to seek routine screening for the HIV antibody.

g. Voluntary screening. Any HCB (including civilian employees assigned overseas) may voluntarily request screening and will be accommodated as soon as possible, confidentially, on a space-available basis at fixed Army AD MTF. This service should be widely publicized and made easily accessible to encourage its use. Such testing must always be accompanied by thorough counseling. Individuals who engage in high risk behaviors, such as having sex with known HIV-infected persons or having multiple sexual partners, will be encouraged to cooperate in testing and counseling. Family members who are concerned about whether they have been exposed to HIV should consult with personnel in the Preventive Medicine Service. As is the customary procedure for personal medical concerns, the family member may obtain an appointment and discuss his or her concerns directly with the health care practitioner. Appropriate supporting tests, including laboratory evaluation, will be determined by the physician.

h. Routine adjunct testing. The following persons will be routinely offered HIV testing and counseling:

(1) All persons admitted to Army hospitals unless tested during the preceding 12 months. Patients under age 15 or older than 65 should not be screened unless clinically indicated. Infant admissions should be tested unless there is documentation that the mother had a negative HIV antibody test during pregnancy.

(2) All pregnant women at the time of their initial prenatal evaluation. Testing should be repeated just prior to or at the time of delivery, if the mother has been identified as being at high risk.

(3) All persons enrolled in ADAPCP (Tracks II (individual counseling) or III (short term residential rehabilitation)).

(4) Complete (as opposed to limited or walk-in symptom focused) physical examinations in adults 15 years of age and older should routinely include an HIV antibody screening test unless a test has been performed during the preceding 12 months. This includes school or sports physical examinations for adolescents age 15 or older and premarital examinations performed overseas under the provisions of AR 608–61.

(5) All patients requiring treatment in emergency rooms with evidence of trauma, such as shootings, stabbings, and rape.

(6) All persons with acute or chronic hepatitis B infection.

(7) All persons who are dead on arrival or who die in emergency rooms.

6–3. Consent requirements

a. Nonactive duty HCBs will be informed that their physician will order any clinically indicated laboratory tests necessary to properly treat the patient, to include an HIV test. As part of the in-patient admissions process, the patient will be provided a consent form on which the patient will give or withhold consent for HIV testing as clinically indicated. In outpatient clinics, nonactive duty HCBs will be verbally counseled by the physician who desires to order an HIV test as to the reason for ordering the test. The physician will obtain the patient's verbal consent prior to drawing blood for the test and will record the consent (or lack of consent) in the patient's medical treatment record. In emergency situations when the patient is incapacitated and unable to give consent, the physician may order an HIV test

if clinically indicated. In non-emergency situations when the patient is incapacitated and unable to give consent, the physician will obtain consent from the next of kin or legal guardian.

b. Patients may decline certain medical procedures or laboratory tests. Should this occur, the health care provider will document this refusal in the patient's treatment record. The patient will not be denied care as a result of refusing certain procedures or tests. However, the patient will be advised that refusing these procedures or tests may result in the physician altering the manner in which he or she will treat the medical condition or complaint for which the patient seeks care.

c. Patients will be informed of positive test results of any physician-ordered HIV testing as prescribed in paragraph 6–8. If a physician-ordered HIV test result is antibody positive, the physician will ensure that medical evaluation and counseling is offered per paragraphs 2–12 and 2–13. Any patient testing HIV antibody positive will be provided information explaining the nature of the test, possible results, and their meaning. A handout may be used for this purpose. In addition, each patient will be provided a copy of the Scriptographic booklet entitled, "HIV and AIDS," or an equivalent DOD-approved educational publication. After reviewing the material, patients will be afforded the opportunity to ask questions of an appropriate health care professional concerning the test.

6–4. Medical functions

Medical functions will be as indicated in paragraph 2–3.

6–5. Medical support

Medical support for HIV testing of family members and other HCBs will be as indicated in paragraph 2–4.

Section II
Family Member and Other Health Care Beneficiaries Policies and Procedures

6–6. Clinical evaluation

HIV-infected HCBs will be offered the opportunity and encouraged to undergo complete medical evaluation at the MEDCEN servicing the HSR. The evaluation will be conducted per the standard DOD clinical protocol and will be reported as required in this regulation.

6–7. Medical records

a. The medical and dental record jacket for all HIV-infected HCBs will be marked only by affixing a DA Label 162 (Emergency Medical Identification Symbol) per AR 40–15. The master problem list will be annotated "Donor Ineligible-V72.62."

b. Records pertaining to staging and evaluation of HIV-infected HCBs will be filed per AR 40–66.

6–8. Individual notification procedures

a. All HCBs and spouses of HIV-infected soldiers will be individually and privately notified of all positive HIV test results in a face-to-face interview with a physician.

b. The designated physician will notify HCBs of the initial HIV positive test. The individual will be informed that they have a positive Western Blot, that it may mean he or she is infected by HIV and, if confirmed to be infected by a second or subsequent test, they will be referred for further medical evaluation. Individuals will be advised not to donate blood, tissues, organs, or semen and to refrain from sexual relations until the results of the confirmatory tests are available. Test results of family members will not be reported to the sponsor's command authorities. The family member concerned and the sponsor will be advised of the results and counseled per paragraph 2–2g by medical personnel.

c. Notification of contacts of HIV-infected personnel will be as follows:

(1) HCBs who are sexual partners of known AIDS patients, individuals who are HIV-infected, or individuals who were transfusion or blood product recipients from HIV-infected donors will be advised by medical authorities to seek medical evaluation as soon as possible.

(2) Information should be reported to civilian public health authorities, per local jurisdiction reporting requirements, when information is obtained through the epidemiological assessment interview indicating that individuals—

(a) Who are not military personnel or military HCBs are sexual partners of known AIDS patients or of people who are HIV-infected, or

(b) Were transfusion or blood product recipients from HIV-infected donors.

6–9. Notification and testing of spouses of HIV-infected soldiers

a. Spouses of AD soldiers will be notified of the sponsor's HIV infection by the PMP. The PMP will recommend that the spouse be tested for HIV. However, such testing is voluntary. If the spouse chooses to be tested, the PMP will ensure that preventive medicine counseling is conducted per paragraph 2–13.

b. Spouses of RC soldiers are normally not health care beneficiaries. However, spouses of HIV-infected RC soldiers

will be designated by the Secretary of the Army as limited health care beneficiaries for purposes of receiving HIV testing and counseling if they so choose. NGB and OCAR will publish procedures for informing spouses of HIV-infected RC soldiers of the sponsor's infection and for offering voluntary HIV testing and counseling.

c. Information pertaining to HIV-infected spouses will be reported through designated channels to local public health authorities. For spouses of AD soldiers, the PMP will report that information to local public health authorities per local jurisdiction reporting requirements. OTSG will publish guidance for reporting this information. For spouses of RC soldiers, information will be provided to the State or CONUSA HIV Program POC. That information will, in turn, be provided to the State or local jurisdiction public health authority dealing with HIV/AIDS per State or local law or reporting requirements. NGB and OCAR will publish guidance for reporting this information.

6–10. Preventive medicine counseling

All HIV-infected HCBs will be given the preventive medicine counseling prescribed in paragraph 2–13.

6–11. Monitoring patient health

a. Long term monitoring of the patient's health is essential; complete restaging will be accomplished annually as a minimum. Disease progression must be monitored closely and updates provided promptly to USAHDS for data base inclusion.

b. Medical records for family members and other HCBs will be transferred per guidance in paragraph 4–8 whenever the HCB relocates to another installation.

6–12. Accompanied tours

a. Family members who are HIV-infected may accompany their sponsor overseas. If initial diagnosis of a family member occurs while at an overseas location, the family member will be encouraged to undergo immediate detailed medical evaluation and staging. Test results of family members will not be reported to the sponsor's command authorities. The family member concerned and the sponsor will be advised of the results and counseled per paragraph 2–2g by medical personnel. If clinical illness is present or evaluation is desired, the family member will be processed for medical evacuation to the Army medical center designated and will ordinarily be returned to the overseas location on completion of evaluation.

b. No section

6–13. Child Development Services

a. Placement of an HIV-infected child into Army-sponsored Child Development Services (CDS) programs will be determined on a case-by-case basis. The goal of the placement decision is to provide the optimal setting for care based on the overall health status of the child. Factors which will be considered in the decision include neurological development, behavior, and immune system status. Consideration will also be given to special circumstances in which the protective environment of a special purpose family child care home would be more appropriate (i.e., need for stringent infection control procedures to protect an HIV-infected child from communicable disease).

b. The placement decision will be made by a team consisting of the child's physician, his or her parents, the CDS coordinator, the preventive medicine physician, and the community health nurse. If this team is unsure of the appropriate placement decision, additional personnel at the medical center servicing that installation's health service region or at the installation's MACOM headquarters may be consulted. Confidentiality of the information regarding the child and his or her parents will be maintained by all personnel involved in the decision.

c. Knowledge of the child's HIV status will be limited to those who have a legitimate need for that information taking into account the following:

(1) Specific infection control procedures needed to protect the child or the child's care givers.

(2) Home health procedures dictated by the child's medical treatment plan.

(3) The need for a supportive environment due to developmental, neurological, or behavioral deficiencies.

6–14. Exceptional Family Member Program

When a family member of an AD soldier is confirmed as HIV-infected or diagnosed with AIDS, either by testing through the medical treatment facility or by a civilian practitioner, the primary physician or a member of the HIV clinical staff will notify the Exceptional Family Member Program (EFMP) POC for initiation of enrollment in the EFMP per AR 600–75. The primary physician or a member of the HIV clinical staff will counsel the family member and the sponsor concerning the requirement for mandatory enrollment in the EFMP. The EFMP POC, ICW the HIV clinical staff, will process the family member to ensure confidentiality.

Section III
Polices and Procedures for Civilian Employees

6–15. Testing of civilian employees

a. Normally, neither applicants for employment nor current employees may be required to be tested for the presence

of the HIV antibody. However, pursuant to DOD guidance, HIV antibody testing may be authorized when it is required by a host country. Any such testing will be at no cost to the employee. Assignment or employment may be denied to employees who refuse to comply with this testing requirement, or who have an HIV antibody positive test result. Prior approval to require a civilian employee to be tested for HIV antibody must be obtained from HQDA(DAPE–CPE), WASH DC 20310–0300, when it is determined that a host country requires proof of negative HIV antibody test results. Requests for approval to require an employee to be tested to meet host country requirements must provide documentation of the testing requirement. Requests for exception to the testing policy may not be approved by DA. All requests for exceptions to the testing policy will be forwarded through command channels to HQDA(DAPE–CPE), WASH DC 20310–0300 for review and staffing. DA will forward to DOD and request approval of all meritorious civilian testing requirements and will provide notification of the results of the request to the requesting activity.

b. DA will provide civilian employees who are overseas and authorized medical care at Army MTF the opportunity to be tested for the presence of the HIV antibody on an elective, space-available basis. HIV antibody positive test results will be confidential information and will not be the basis of any adverse actions concerning the individual's employment. (See *e*below). Employees and their family members will be encouraged to obtain further diagnosis or treatment. Charges for this testing may be waived per AR 40–3, paragraph 3–2b(12).

c. Overseas commands will establish policies pertaining to foreign national employees that, to the degree permitted by local law and custom, are consistent with these policies.

d. Employment or assignment will not be denied solely on the basis of the confirmed presence of the HIV antibody, except in those instances where a host country requires HIV testing with negative results.

e. The presence of AIDS or the HIV antibody will not, by itself, be the basis of any adverse personnel action against an employee. Existing civilian employment policy provides guidance relating to appropriate action when employees are not physically able to carry out the duties of their job.

f. Because of the small, but important, risk of health care providers contracting blood-borne infections, such as HIV, all civilian health care workers will be encouraged to be tested periodically, particularly those employees exposed frequently to blood or body fluids from patients.

g. Civilian health care providers sustaining a laceration or needlestick injury with possible transmission of disease will be advised to be tested following injury and at periodic intervals and to be followed medically. Of particular concern are instances where blood or body fluids from an HIV-infected patient may be accidentally introduced into the employee. Such employees should be immediately referred to a staff physician of the HIV program for evaluation and testing. They should be tested at the time of the incident, 3 to 6 months after, and again at 12 months after exposure to detect seroconversion in latent infections resulting from the accidental exposure.

6–16. Guidelines for handling issues related to HIV infection and AIDS

a. These guidelines are intended to assist managers and supervisors of civilian employees in dealing with AIDS/HIV related personnel issues arising in the workplace. They provide managers and supervisors of civilian employees a basic framework on how to approach and resolve such issues. Specific technical advice and assistance should be obtained from the servicing Civilian Personnel Office (CPO), MTF, and legal office in resolving individual cases.

b. Guidelines issued by the Public Health Service's Centers for Disease Control dealing with AIDS/HIV in the workplace state that "the kind of nonsexual person-to-person contact that generally occurs among workers and clients or consumers in the workplace does not pose a risk for transmission of (AIDS)." Therefore, employees in the workplace who have been diagnosed as, or suspected of being, HIV-infected should not be treated differently than other employees. They should be allowed to continue working as long as they are able to maintain acceptable performance and do not pose a significant safety or health threat to themselves or others in the workplace. If serious performance or safety problems arise, supervisors and managers should address them by applying existing Federal and Army civilian personnel policies and practices.

c. There is no medical basis for employees refusing to work with fellow employees or agency clients who are, or are suspected of being, HIV-infected. Nevertheless, the concerns of employees who fear working with HIV-infected co-workers should be taken seriously and should be addressed with appropriate information and counseling. In addition, employees, such as health care providers, who may come into direct contact with HIV-infected persons, or with their body fluids, should be provided appropriate information and equipment to minimize the risks of such contact.

d. Managers and supervisors should treat HIV-infected employees in the same manner as employees who suffer from other serious illnesses. This means, for example, that employees may be granted sick leave or leave without pay when they are incapable of performing their duties or when they have medical appointments. An employee with AIDS/HIV-related conditions may be an "individual with handicaps" under the Rehabilitation Act of 1973, as amended, and Equal Employment Opportunity Commission regulations and may be entitled to "reasonable accommodation." Managers and supervisors are encouraged to consult with their local legal office to determine their rights and obligations in any specific case.

e. Consistent with the Department of the Army's concern for employees with AIDS/HIV infection, the following resources are available:

(1) Management and employee education and information on specific life-threatening illnesses through the activity MTF.

(2) Referral to agencies and organizations which offer support services for persons with AIDS or HIV infection through the ADAPCP civilian counseling services, MTF, or Employee Assistance Program (EAP) counseling and referral services.

(3) Benefits consultation from the CPO to assist employees in effectively managing health benefits, leave, insurance, and other benefits.

f. When dealing with situations involving an employee with AIDS or HIV infection, managers and supervisors should:

(1) Understand that HIV infection or AIDS will not, absent other considerations, be the basis for taking any adverse personnel action against an employee.

(2) Remember that information concerning an employee's health is personal and confidential, and once such information becomes part of an employee's file, it is covered by the Privacy Act. Accordingly, such information can be released only to agency officials who have a need to know. Further, supervisors and management officials should ensure that precautions are taken to protect all information regarding an employee's health. (See AR 40–66 and AR 340–21). Any questions concerning disclosure of such information should be directed to the local staff judge advocate.

(3) Contact MTF personnel for information about a specific life-threatening illness or the contagious nature of an illness. The servicing CPO also should be contacted regarding additional guidance in managing a situation that involves an employee with AIDS or HIV infection.

(4) Contact CPO or MTF personnel if it is determined additional information should be obtained from the employee's physician to assist in determining if the employee's presence at work will pose any threat to the employee or co-workers.

(5) Be understanding, compassionate, and sensitive to the fact that continued employment for an employee with a life-threatening illness may sometimes be therapeutically important in the remission or recovery process, or may help to prolong the employee's life.

(6) Encourage employees with AIDS or HIV infection to seek assistance from established community support groups for medical treatment and counseling services. Information on these services can be requested through the ADAPCP, MTF, and/or EAP programs.

(7) Be sensitive and responsive to co-workers' concerns, and emphasize employee education available through CPO and MTF.

(8) Give no special consideration beyond supplying appropriate information, counseling, or training to employees who feel threatened by an HIV-infected co-worker. Disciplinary action may be taken against any employee whose refusal to work with an HIV-infected employee causes disruption in the workplace.

Chapter 7
Limited Use Policy

7–1. Purpose

The purpose of this chapter is to specify limitations on the use of information regarding HIV testing results and medical evaluation.

7–2. Limitations on the use of laboratory test results

a. Test results confirming that a soldier is HIV-infected may not be used against the soldier—

(1) As the basis for any disciplinary or adverse administrative action, except for the following:

(a) Separation for physical disability. However, soldiers who are HIV-infected but are determined by medical authorities to show no sign of progressive clinical illness or immunological deficiency will not be separated for physical disability solely because of HIV infection.

(b) Separation under the accession testing program of soldiers meeting the definition of accession (chap 3).

(c) Separation as specifically authorized by paragraphs 4–12 through 4–14.

(2) As a basis for an unfavorable entry in a personnel record (see para 7–5 below).

(3) To characterize service.

b. This policy does not impose any other restrictions on the use of test results within DOD. Nothing in the restrictions in a above precludes the use of such laboratory test results in any other manner consistent with law or regulation including:

(1) To establish the HIV infection status of a soldier who disobeys the preventive medicine counseling, the commander's counseling, or both, in an administrative or disciplinary action based on such disobedience.

(2) To establish the HIV infection status of a soldier as an element of any other permissible administrative or

disciplinary action (for example, as an element of proof of an offense charged under the Uniform Code of Military Justice (UCMJ)).

(3) To establish the HIV infection status of a soldier as a proper ancillary matter in an administrative or disciplinary action (for example, as a matter in aggravation in a court-martial in which the HIV-infected soldier is convicted of an act of rape committed after he is informed that he is HIV-infected).

c. Laboratory test results will receive the same protection as any other medical information per AR 40–66. Medical authorities are required to report test results indicating that a soldier is HIV-infected to the soldier's chain of command. Although the use of this information by commanders is not limited except as described above, commanders will treat the information with due regard for the privacy of the soldier concerned.

7–3. Limitations on the use of certain other information

a. As part of the effort to control the spread of HIV infection and to develop medical and scientific information concerning the infection, AD soldiers (including AGR and other Reservists who, because of their status, are entitled to military medical care) who are identified as HIV-infected will be questioned by medical authorities concerning possible sources of their exposure to the virus. This medical evaluation process is called an epidemiological assessment. Information that a soldier may provide to medical authorities during this assessment may not be used against the soldier or other named third parties except as authorized by this paragraph. Such protected information includes, for example:

(1) Information concerning a soldier's personal use of drugs.

(2) Information concerning consensual homosexual or heterosexual activity, even if that sexual activity is prohibited by law or regulation.

b. Information obtained during, or as a result of, an HIV epidemiological assessment may not be used against the soldier or other named third parties—

(1) In a court-martial.

(2) In a nonjudicial punishment action (Article 15, UCMJ).

(3) In a line of duty determination.

(4) As a basis, alone or in conjunction with other information, for the involuntary separation of a soldier, except a separation for physical disability. If the information is used in a physical disability separation procedure, the information may not be used on the issue of whether the disability was due to the soldier's own misconduct.

(5) In an administrative or punitive reduction in grade.

(6) For denial of a promotion.

(7) In a bar to reenlistment.

(8) As the basis for an unfavorable entry in a personnel record.

(9) As a basis, in whole or in part, to characterize service or to assign a separation program designator.

(10) In any other action considered to be an adverse personnel action (for example, comment in an Officer Evaluation Report or an NCO Evaluation Report).

7–4. Exclusions

The limitations in paragraph 7-3 on the use of information do not apply to the following:

a. The introduction of evidence for impeachment or rebuttal purposes in any proceeding in which the evidence of drug abuse or relevant sexual activity (or lack thereof) has been first introduced by the soldier.

b. Disciplinary or other action based on independently derived evidence.

c. Nonadverse personnel actions such as—

(1) Reassignment.

(2) Disqualification (temporary or permanent) from a personnel reliability program.

(3) Denial, suspension, or revocation of a security clearance.

(4) Suspension or termination of access to classified information.

(5) Removal (permanent or temporary) from flight status or other duties requiring a high degree of alertness or stability (for example, explosive ordnance disposal) or restricting the duties of HIV-infected health care providers.

d. Any evidence or information derived from sources independent of an epidemiological assessment. For example, admissions of drug abuse or homosexual conduct by an HIV-infected soldier, not made in the context of an epidemiological assessment, may be used as evidence in an administrative or disciplinary action against the soldier.

7–5. Entries in personnel records

In the event that personnel actions are taken as a result of, or are supported by, serologic evidence of HIV infection, or information described in paragraph 7–3, care will be taken to ensure that no unfavorable entry is placed in a personnel record in connection with the action. Recording a personnel action in a personnel record is not itself an unfavorable

entry in such a record. Also, information that reflects an individual has serologic or other evidence of HIV infection is not an unfavorable entry in a personnel record.

Chapter 8
HIV Information and Education Plan

8–1. General

This chapter establishes—

a. The minimum requirements for providing information and education about HIV to the Total Army family.

b. Responsibilities to ensure the HIV information and education program is successful.

c. Resources available to the Army community in carrying out this information and education plan.

8–2. Basic structure of the plan

The HIV information and education plan consists of three components:

a. Providing basic information about the Army's HIV policy and testing program, Army accomplishments in HIV research, and information suitable for general audiences concerning the nature of HIV disease. Target populations for this information include soldiers and their family members, DA civilian employees, and audiences external to the Army in efforts to promote Army accomplishments.

b. Educating the Total Army family. This effort is intended to provide members of the Army family with information concerning the basic characteristics of HIV infection and its stages, how they can protect themselves from exposure to HIV infection, and how they can educate others.

c. Educating and training health care providers. This effort is specifically oriented to equipping health care providers to perform their duties while avoiding occupational exposure to HIV infection and other bloodborne infectious diseases.

8–3. HIV/AIDS Education Program Coordinator

The Community Health Nurse consultant to TSG is designated as the HIV/AIDS Education Program Coordinator to serve as the focal point for all HIV/AIDS education program issues and, in conjunction with HQDA(DAPE–HR), to integrate the educational activities of the Army.

8–4. HIV information plan

a. Execution of the Army HIV information plan is primarily the responsibility of the public affairs community. The objectives of the plan are to—

(1) Inform all Army soldiers, civilians, and family members about the Army's HIV/AIDS policy.

(2) Inform internal and external publics about the Army's research and clinical investigation efforts on HIV/AIDS prevention and treatment.

(3) Disseminate accurate information on HIV/AIDS to include prevention, treatment, and transmission. This effort will be directed toward dispelling inaccurate information and rumors.

(4) Inform internal and external publics regarding Army implementation of DOD directives on HIV/AIDS programs.

b. The following are key points to be stressed in the Army information effort:

(1) The Army's two primary concerns are readiness and the welfare of our soldiers, civilians, and their family members. The HIV testing program is designed to identify HIV-infected soldiers so that they may receive early treatment, be counseled on how to prevent transmission, and to preserve unit readiness.

(2) Accurate information on transmission of the disease.

(3) The potentially devastating impact of the disease on Army readiness (deployability) if not effectively identified and controlled.

(4) Requirements for immunization and ensuring a reliable, safe blood supply among military personnel.

(5) Efforts by Army medical researchers in assisting the national effort to find a cure and effective treatments for HIV/AIDS.

(6) Procedures developed to ensure a reliable blood supply.

(7) Specific policies pertaining to HIV/AIDS as they apply to the Total Army.

8–5. HIV education plan for the military community

a. The community education plan is a planned, systematic process designed to provide a quality HIV education program for military personnel and other DoD HCBs with emphasis on soldiers, commanders and supervisors, the civilian work force, and family members. Ensuring that an effective education plan exists is the responsibility of the installation commander; providing the setting in which the plan may be successfully implemented is primarily the responsibility of unit commanders.

b. An effective education plan includes information presented in varied formats and with content appropriate to the members of the target audience. The session includes—

(1) Application of adult learning principles.

(2) Current information related to HIV infection, testing, and policies.

(3) A learning needs assessment and a menu of behavior options related to relative risk of HIV infection.

(4) A planned, systematic mechanism for monitoring and evaluating the HIV education process.

(5) Implementation of corrective action, followup, and reevaluation, when indicated.

c. The primary resources available to commanders for design development and implementation of an effective education plan are in the MEDDAC Preventive Medicine Service (PMS). The PMS has the expertise and is actively involved in the installation health promotion program and health education process for individuals and groups in a wide variety of health-related topics. Additional resources include the installation and unit chaplains, the Management and Employee Relations and Training staffs of the CPO, recognized labor unions, and the learning resource centers.

d. In collaboration with commanders, MTF staff, civilian personnel representatives, and other interested installation agencies, the PMS will develop an installation HIV education plan which will include specific educational designs for military, family member, and civilian personnel. Each design will be specifically tailored for the intended audience. As a priority, HIV education will be provided yearly to military personnel and civilian employees. Classes for family members will depend on the availability of resources. The PMS, other MTF staff, trained civilian personnel, chaplains, and knowledgeable staff from civilian agencies may coordinate resources to provide needed health education.

e. To execute the HIV education plan for the military community, the following policies are assigned:

(1) Commander, Training and Doctrine Command (TRADOC) will ensure that existing health awareness/education blocks of instruction in all Army schoolhouse and initial entry training courses incorporate basic HIV/AIDS instruction. This instruction should focus on behaviors which place an individual at high risk of exposure to HIV, methods of transmission, measures to protect against exposure, and Army requirements for HIV testing.

(2) Installation commanders will ensure development of, and approve, an HIV education plan targeting commanders and supervisors, family members, and civilian employees. These commanders will further support the education plan by providing adequate personnel resources, classrooms, equipment, and other resources required for a successful program. To ensure HIV education programs reach all targeted personnel, classes will be included in the installation's master activity calendar.

(3) Supervisors of civilian employees will ensure that all civilian employees receive training on HIV infection and AIDS in the workplace, with emphasis on appropriate actions and behaviors when encountering HIV/AIDS in the workplace. Chapter 6 provides guidance for handling HIV/AIDS in the workplace issues.

(4) For family members, HIV education should include an emphasis on high risk behaviors and methods of preventing infection, including safer sex instruction. Family member education may be accomplished in conjunction with a variety of other installation activities to include—

(a) Community counseling centers.

(b) Health care facilities caring for family members.

(c) Recreation centers.

(d) Libraries.

(e) Chapel or religious education activities.

(f) Chaplain Family Life Centers.

(g) Youth activity programs.

(5) Unit commanders will ensure that their soldiers attend at least one HIV education class annually. They will request assistance from the servicing medical facility as needed to comply with this requirement.

(a) Because of individual rotation and to provide flexibility in scheduling, commanders will ensure that HIV education is offered at least quarterly. The education plan will be incorporated into the unit's quarterly training schedule.

(b) RC units may conduct this training annually prior to unit testing.

(6) Commanders at all levels will make HIV education a matter of special interest within their Organizational Inspection Program. The goal of the review should be to assess the existence and effectiveness of installation and unit education programs.

8–6. Educating and training health care providers

OTSG is responsible for ensuring that education and training programs are developed and implemented for health care providers. Included in this group are health educators, primary care providers, STD interviewers and counselors, drug and alcohol counselors, and Occupational Safety and Health personnel. Education for these individuals should focus on enabling them to perform their duties following the guidelines published by the Centers for Disease Control and the Occupational Safety and Health Administration. Their training should also equip them to provide counseling to at risk

patients as a normal part of their duties. MTF commanders are responsible for implementing HIV education and training for health care personnel at their installations per the education plan developed by OTSG.

8–7. Resources

Commanders have many resources available to conduct an HIV information and education plan. They should make full use of the installation public affairs outlets for getting out information. The PMS provides an excellent resource for helping to develop innovative education strategies. The Army has two video tapes available through training aids support offices: "Nobody's Immune,"SAVPIN 702115 DA TVT 8-118; "AIDS: A Soldier's Story," SAVPIN 706922 DA TF(VT) 8-6366. There are many excellent commercially produced videos which may be used. The local public health authorities in many locations have excellent programs and materials which they may be willing to share.

Chapter 9
Law Enforcement and Corrections Policies and Procedures

Section I
Army Law Enforcement and Security Policies and Procedures

9–1. Purpose

This section provides policies and procedures for Army law enforcement and security personnel to prevent duty-related exposure to HIV infection. The information contained herein is consistent with model HIV policies published by the Centers for Disease Control.

9–2. Precautionary measures against duty-related exposure

Although the likelihood of direct exposure to HIV infection is relatively small, reasonable precautionary measures are warranted. Army law enforcement and security personnel frequently respond to situations in which they may come in contact with body fluids or objects contaminated with HIV. Examples include serious traffic accidents, injuries, and crimes of violence (murder, rape, robbery, aggravated assault).

a. In situations where exposure to body fluids as described above is possible (but not likely), the following precautions should be taken:

(1) Cover and protect open wounds, cuts, and irritations from possible contamination.

(2) Use one-way airway devices when administering mouth-to-mouth resuscitation.

(3) Use sealable plastic bags to collect soiled and stained items consistent with established crime scene processing procedures (AR 195–5).

(4) Avoid or minimize direct contact with body fluid spills or potentially contaminated objects and, should contact with body fluids be made, wash exposed areas with soap and hot water as soon as possible.

b. In situations where exposure to body fluids is likely, the following precautions, in addition to those listed above, must be taken:

(1) Wear impermeable gloves (rubber or latex).

(2) Exercise caution to avoid punctures or cuts.

(3) Wear protective overgarments to include footwear and head gear.

(4) Use caution when searching and wear heavy-duty gloves to avoid puncture wounds.

9–3. Clean-up and disinfecting procedures

a. The following procedures should be followed when cleaning potentially HIV-infected items and areas:

(1) Avoid direct contact with soiled or stained items.

(2) Clean spills and stains with approved solutions (1:10 bleach to water mix).

b. In addition, the personal hygiene measures outlined below should be applied after potential exposure:

(1) Avoid eating, drinking, or smoking until after cleaning up.

(2) Shower the entire body with soap and hot water as soon as possible after exposure.

(3) Launder or dry clean soiled clothing before wearing them again.

9–4. Availability of equipment and supplies

a. Installation provost marshals and security officers must ensure that each post and patrol has ready access to protective and decontamination equipment and supplies including:

(1) Impermeable gloves (rubber or latex).

(2) One-way airway devices (adult and pediatric sizes).

(3) Sealable plastic bags.

(4) Suitable protective overgarments.
(5) Heavy-duty gloves (for conducting searches).
(6) Decontamination solution (household bleach).

b. When feasible, the use of disposable items is recommended.

9–5. Documentation of possible direct exposure

Provost marshals and security officers must immediately refer for medical examination, evaluation, and follow-up any Army law enforcement personnel who receive direct percutaneous (through a break or cut in the skin) contact with body fluids from an individual. Such cases must be thoroughly documented and carefully monitored by provost marshals and security officers. Resulting records (military police reports, traffic accident investigation reports, desk blotters, duty journals, and other documents) must be protected as sensitive information (FOR OFFICIAL USE ONLY) releasable on a need-to-know basis per AR 25–55 and AR 340–21.

9–6. Orientation and training

Army law enforcement personnel will attend awareness training on the causes, methods of transmission, and prevention of duty-related HIV infection at least annually. This requirement does not exempt military personnel from the HIV education requirements of chapter 8. Training will be developed in concert with the local MTF and must reflect the basic tenets of DA policy on HIV as outlined in this regulation. (Special attention will be directed toward ensuring law enforcement and security personnel are properly trained on the use of one-way airway devices.) This training will include realistic demonstrations and hands-on practical exercises. Newly assigned personnel will attend training prior to being utilized for operational law enforcement or security duties.

9–7. Policy implementation

Installation provost marshals and security officers are responsible for developing and implementing local memoranda of instruction (MOI), standing orders, and standing operating procedures (SOPs) necessary to implement the requirements of this regulation. However, in clearly life-threatening situations, the inability to comply with the foregoing policies and procedures, or the lack of prescribed equipment or supplies, is not sufficient justification to either delay or deny emergency aid or assistance. Law enforcement and security personnel are expected to use sound judgment and good common sense in applying these policies.

Section II
Army Correctional System Policies and Procedures

9–8. HIV in correctional facilities

HIV has become a major policy and management issue for correctional administrators. Correctional institutions have become a focus of concern about the disease.

9–9. Purpose and applicability

The information and guidelines contained in this section have been developed for correctional staff to assist in the identification and management of inmates infected with HIV. The policies presented are intended to provide overall guidance in preventing the transmission of HIV within the Army Correctional System (ACS), as well as protecting the confidentiality of HIV-infected inmates and reducing the anxiety and misunderstanding about the disease within the ACS.

9–10. Inmate testing program

a. All inmates will be tested for HIV within 24 hours of entering confinement. Inmates who are determined to be HIV negative will be retested at least annually as part of a program to monitor and detect any transmission of HIV in the facility.

b. Should incidents which could result in the transmission of HIV (for example, sexual contact, tattooing, intravenous drug use, or body fluid transfer) occur in confinement or correctional facilities, the participants will be immediately tested for HIV. If all of the participants are known to be HIV-infected, testing is unnecessary. In incidents where at least one of the participants is found to be, or is known to be, HIV-infected, all HIV negative inmates involved in the incident will be retested for HIV at three month intervals for one year from the date of the incident.

c. Any inmate who, at any time, shows clinical signs or symptoms of HIV infection as determined by medical authorities will be tested for HIV.

d. Any inmate who has, or acquires, an STD will be tested for HIV unless medical authority determines testing is unnecessary.

e. Except in cases where HIV testing has been done for other reasons within 90 days of their release date, all inmates will be retested for HIV within 30 days of their scheduled date of release from confinement.

f. HIV testing of any inmate may be considered any time the confinement/correctional facility commander, in

concert with the MEDDAC commander, deems it necessary for the safe operation of the facility or health and welfare of the personnel (inmates and staff) in his or her command.

9–11. Confidentiality

Results of all HIV tests must be kept confidential. Personnel who have access to medical, dental, and correctional records will be counseled regarding the confidentiality aspects of HIV infection. Only those personnel, designated by the facility commander, with a legitimate need to know which inmates are HIV-infected will be informed. Correctional Treatment Files (CTF) and other correctional records will not be annotated to reflect the inmate's HIV infection. Recording of medical and dental records will be per paragraph 2–10. Inmates who are HIV-infected will be discouraged from telling anyone other than medical, psychological, and dental personnel. Any statements made by inmates in military and/or correctional records to the effect that they are HIV-infected will remain in such records and will not be expunged. Normally, only medical records may contain indications that an inmate is HIV-infected.

9–12. Inmate transfers

All inmates who are transferred from one confinement or correctional facility to another will be accompanied by a letter of transmittal from the losing facility commander to the gaining facility commander. The letter of transmittal will inform the gaining facility commander of the inmate's medical condition. Paragraphs 2–14d and 4–8 provide additional guidance for the facility commanders. If an inmate is transferred with HIV test results pending, those results will be forwarded to the gaining facility commander by preventive medicine personnel as soon as possible per paragraph 2–12.

9–13. Inmates returning to confinement

All inmates who return to confinement after having been absent from the facility (temporary home parole, parole revocation, trial by or otherwise in the custody of civil authorities) will be considered for retesting. Factors to be considered include whether the inmate was in a geographic area with a high incidence rate of HIV infection or other high risk situation.

9–14. Inmate requested testing

Inmates who voluntarily request HIV testing will be medically evaluated and counseled by appropriate medical staff prior to, and after, being tested.

9–15. MEDCEN evaluation

a. Within seven calendar days after receiving results that an inmate is HIV-infected, the inmate will be scheduled for evacuation to a MEDCEN for initial medical evaluation, counseling, treatment, and other medical attention as necessary. Immediately following such evaluation and appropriate treatment, the inmate will be returned to the designated confinement/ correctional facility.

b. All HIV-infected inmates will be reexamined and reevaluated at a MEDCEN at least annually, or as determined necessary by local medical authorities.

9–16. Medical management in confinement

a. All HIV-infected inmates will be evaluated and managed on a case-by-case basis. The Walter Reed Staging System will not be used as a management tool by confinement facility personnel.

b. The medical condition of HIV-infected inmates will be monitored by the local MEDDAC. Frequency of medical visits will be every 4 to 6 weeks, or as deemed appropriate by medical authorities.

c. All HIV-infected inmates will be provided emotional and psychosocial support by counselors trained in working with HIV-infected individuals.

d. Immediately prior to any HIV-infected inmate's release from confinement, military preventive medicine authorities will report applicable information to civilian public health authorities for the state into which the inmate will be released. Reporting will be per applicable statutes of that state and paragraphs 2–3b(11) and (13).

9–17. Routine confinement practices

a. HIV-infected inmates will not be segregated from the general inmate population based solely on the fact they are HIV-infected.

b. Normally, the handling of laundry and linen of HIV-infected inmates will be no different than for other inmates. In certain cases, determined by medical authorities, special handling of contaminated laundry/linen may be necessary.

c. Toilet and shower facilities for HIV-infected inmates will not be separate or different from those used by other inmates in the same custody grade.

d. Food service sanitation provisions for HIV-infected inmates will be no different or separate from other inmates, to include dishwashing and garbage handling procedures.

9–18. Work, training, restoration, parole, and clemency

a. HIV-infected inmates will be assigned to work and training programs per AR 190–47 and this regulation.

b. Recommendations for clemency and parole should not be made based solely upon HIV seropositivity.

9–19. Segregation of HIV-infected inmates

a. HIV-infected inmates who fear being with the general inmate population will be considered for, and may be placed in, administrative segregation. Upon their request, and as deemed necessary by the facility commander, they may be placed in protective custody.

b. All HIV-infected inmates who are (beyond mere suspicion) sexually active, sexually aggressive, or otherwise physically aggressive, may be placed in administrative segregation in single cells. They should not be permitted to eat, work, train, or have recreation with any other inmate.

9–20. Transfer of HIV-infected inmates

a. HIV-infected inmates in the ACS will not be transferred to other confinement/correctional facilities, or centrally confined at any one facility, based solely on their HIV infection status unless deemed necessary by medical authorities.

b. HIV-infected inmates who medical authorities deem in need of special medical attention will be transferred to the United States Disciplinary Barracks (USDB). They will be maintained in administratively segregated, special quarters inside the USDB, in the USDB hospital ward at Munson Army Hospital, or in Fitzsimons Army Medical Center as deemed necessary by medical authorities. HIV-infected inmates within 90 days of release from confinement will normally not be transferred to the USDB.

9–21. Use of force against HIV-infected inmates

In those circumstances requiring the application of force against an HIV-infected inmate, the force will be applied in a manner consistent with that for other inmates. In situations requiring specially trained and protected personnel (for example, special operations/response teams), all team members will be advised that the inmate is HIV-infected.

9–22. Protection of staff

Confinement/correctional facility staff should have protective clothing and equipment available to them when there is potential for exposure to the blood or body fluids of any inmate. One-way airways should be used for all cardiopulmonary resuscitation situations. Additionally, the following protective items should be immediately accessible: impermeable disposable gloves, heavy gloves, coveralls, overshoes or plastic bags to cover shoes, sealable plastic bags, and cleaning solution (household bleach).

9–23. Counseling

a. HIV-infected inmates will be briefed and counseled per paragraphs 2–13 and 2–14. The commander's copy of the counseling should not be kept in the CTF but, rather, in a separate file. Access to this file will be limited to use as determined by the installation commander and will be handled per the guidance in paragraph 2–14. Any family members of HIV-infected inmates who are HCBs will also be counseled per paragraph 6–9.

b. Prior to release from confinement, HIV-infected inmates will again be counseled. During this session, they will be asked if there is any physician to whom a copy of their medical records can be sent to ensure appropriate continuity of health care. After discharge, the Army will honor a request for medical records when properly submitted per AR 40–66.

9–24. Training

Each confinement/correctional facility will have a comprehensive education and training program for all inmates and staff. This training and education will be conducted per chapter 8 and may be tailored to accommodate concerns of HIV transmission in a confinement/correctional setting.

9–25. Requests for information

Release of HIV-infected inmate population statistics for the USDB, United States Army Correctional Activity, and installation detention facilities will be included in statistical data for the installation releasable under existing DOD and DA policy. However, these statistics will not be identified with the confinement/ correctional facility; they will merely be included in installation totals. Any request for inmate population data and statistics will be forwarded to HQDA (DAMO–ODL), WASH DC 20310–0440.

Appendix A
References

Section I
Required Publications

AR 25–55
The Department of the Army Freedom of Information Act Program (Cited in para 9–5.)

AR 40–3
Medical, Dental, and Veterinary Care. (Cited in para 6–14.)

AR 40–15
Medical Warning Tag and Emergency Identification Symbol. (Cited in paras 2–10 and 6–7.)

AR 40–66
Medical Record Administration. (Cited in paras 2–10, 6–7, 6–15, 7–2, and 9–23.)

AR 40–68
Quality Assurance Administration. (Cited in paras 4–2 and 4–6.)

AR 40–501
Standards of Medical Fitness. (Cited in paras 1–14, 2–1, 3–3, 4–2, 4–5, 4–13, 4–14, 5–11, and 5–18.)

AR 135–175
Separation of Officers. (Cited in paras 5–10, 5–17, and 5–18.)

AR 135–178
Separation of Enlisted Personnel. (Cited in paras 5–10, 5–17, and 5–18.)

AR 140–10
Army Reserve: Assignments, Attachments, Details, and Transfers. (Cited in para 5–17.)

AR 140–50
Army Reserve: Officer Candidate Schools. (Cited in para 3–3.)

AR 190–47
The U.S. Army Correctional System. (Cited in para 9–18.)

AR 195–5
Evidence Procedures. (Cited in para 9–2.)

AR 340–21
The Army Privacy Program. (Cited in paras 6–16 and 9–5.)

AR 351–5
United States Army Officer Candidate School. (Cited in para 3–3.)

AR 600–75
Exceptional Family Member Program. (Cited in para 6–14.)

AR 600–200
Enlisted Personnel Management System. (Cited in para 4–2.)

AR 601–100
Appointment of Commissioned and Warrant Officers in the Regular Army. (Cited in para 3–2.)

AR 601–210
Regular Army and Army Reserve Enlistment Program. (Cited in para 3–3.)

AR 601–280
Total Army Retention Program. (Cited in para 4–5.)

AR 608–61
Application for Authorization to Marry Outside of the United States. (Cited in paras 2–2 and 6–2.)

AR 612–201
Processing, Control, and Distribution of Personnel at U.S. Army Reception Battalions and Training Centers. (Cited in para 4–7.)

AR 614–30
Oversea Service. (Cited in paras 1–14, 4–3, 4–7, and 4–10.)

AR 614–100
Officers Assignment Policies, Details, and Transfers. (Cited in para 4–2.)

AR 614–200
Selection of Enlisted Soldiers for Training and Assignment. (Cited in para 4–2.)

AR 635–40
Physical Evaluation for Retention, Retirement, or Separation. (Cited in paras 1–14, 4–7, 4–12, 4–13, 4–14, and 5–11.)

AR 635–100
Officer Personnel. (Cited in para 4–12.)

AR 635–120
Officer Resignations and Discharges. (Cited in para 4–12.)

AR 635–200
Enlisted Separations. (Cited in paras 3–3, 4–5, and 4–13.)

DA Pam 600–24
Suicide Prevention and Psychological Autopsy. (Cited in para 2–15)

NGR 40–501
Medical Examination for Members of the Army National Guard. (Cited in para 2–1.)

NGR 351–5
State Military Academies. (Cited in para 3–3.)

NGR 600–200
Enlisted Personnel Management. (Cited in paras 5–10 and 5–11.)

NGR 635–100
Termination of Appointment and Withdrawal of Federal Recognition. (Cited in para 5–10.)

NGR 635–101
Efficiency and Physical Fitness Boards. (Cited in para 5–11.)

Section II
Related Publications

AR 5–9
Intraservice Support Installation Area Coordination.

AR 40–5
Preventive Medicine

AR 40–400
Patient Administration

AR 135–18
The Active Guard/Reserve Program

AR 135–133
Ready Reserve Screening, Qualification Records System, and Change of Address Reports

AR 135–200
Active Duty for Training, Annual Training and Active Duty Special Work of Individual Soldiers

AR 140–1
Army Reserve Mission, Organization, and Training

AR 600–63
Army Health Promotion

AR 608–10
Child Development Services

AR 640–2–1
Personnel Qualification Records

DOD Dir 6130–3
Physical Standards for Enlistment, Appointment, and Induction

NGR 40–3
Medical Care for Army National Guard Members

Section III
Prescribed Forms

DA Form 5668
HIV Screening Test Results. (Cited in paras 2–12 and 5–7.)

DA Form 5669–R
Preventive Medicine Counseling Record. (Cited in paras 2–13 and 5–15.)

DA Form 7303
Donor/Recipient History Interview Form. (Cited in para 2–3.)

Section IV
Referenced Forms

DA Form 2A
Personnel Qualification Record, Part I (Enlisted)

DA Form 2B
Personnel Qualification Record, Part I (Officer)

DA Form 2–1
Personnel Qualification Record, Part II

DA Form 3349
Physical Profile

DA Form 4187
Personnel Action

DA Form 4856
General Counseling Form

DA Label 162
Emergency Medical Identification Symbol

SF 88
Report of Medical Examination

SF 557
Miscellaneous Lab Slip

SF 600
Chronological Record of Medical Cases

Glossary

Section I
Abbreviations

AC
active component

ACS
Army correctional system

AD
active duty

ADAPCP
Alcohol and Drug Abuse Prevention and Control Program

ADSW
active duty for special work

ADT
active duty for training

AEA
assignment eligibility and availability

AGR
Active Guard/Reserve

AI
assignment instructions

AIDS
Acquired Immune Deficiency Syndrome

AMEDD
Army Medical Department

ARCOM
Army command

ARNG
Army National Guard

ARPERCEN
U.S. Army Reserve Personnel Center

ASA(M&RA)
Assistant Secretary of the Army (Manpower and Reserve Affairs)

ASI
additional skill identifier

AT
annual training

AUS
Army of the United States

CAR
Chief, Army Reserve

CCH
Chief of Chaplains

CHN
community health nurse

CNGB
Chief, National Guard Bureau

CONUSA
the numbered armies in the continental United States

CPA
Chief, Public Affairs

CPO
civilian personnel office

CTF
correctional treatment files

DA
Department of the Army

DCSPER
Deputy Chief of Staff for Personnel

DEERS
Defense Eligibility Enrollment System

DOD
Department of Defense

DSN
Defense Secure Network

DTF
dental treatment facility

DRC
Director of Reserve Component Support

EAD
extended active duty

EAP
employee assistance program

EDAS
Enlisted Distribution and Assignment System

EFMP
Exceptional Family Member Program

ELISA
enzyme linked immunosorbent assay

EMF
Enlisted Master File

EPTS
existed prior to service

FDA
Food and Drug Administration

FST
foreign service tour

FTARF
full time attrition/retention force (ARNG)

FTNGD
full time National Guard duty

FTRF
full time recruiting force (ARNG)

GuardPERCEN
National Guard Personnel Center

HCB
health care beneficiary

HIV
Human Immunodeficiency Virus

HIVTRRS
HIV Test Result Recording System

HSC
U.S. Army Health Services Command

HSR
health service region

IADT
initial active duty for training

IDT
inactive duty training

IG
inspector general

IMA
Individual Mobilization Augmentee

ING
inactive National Guard

IRR
Individual Ready Reserve

IV
intravenous

JAGC
Judge Advocate General's Corps

MACOM
major Army command

MEDCEN
medical center

MEDCOM
medical command

MEDDAC
medical department activity

MEPS
Military Entrance Processing Station

MOI
memoranda of instruction

MOS
military occupational specialty

MPRJ
Military Personnel Records Jacket

MTF
medical treatment facility

MTOE
modified table of organization and equipment

NCO
noncommissioned officer

NCOES
noncommissioned officer education system

NGB
National Guard Bureau

OASA(M&RA)
Office of the Assistant Secretary of the Army (Manpower and Reserve Affairs)

OASD(HA)
Office of the Assistant Secretary of Defense for Health Affairs

OCAR
Office of the Chief, Army Reserve

OCONUS
outside continental United States

OCPA
Office of the Chief of Public Affairs

OCS
officer candidate school

ODCSPER
Office of the Deputy Chief of Staff for Personnel

ODT
overseas deployment for training

OMF
Officer Master File

ORB
Officer Record Brief

OTJAG
Office of The Judge Advocate General

OTRA
other than Regular Army

OTSG
Office of The Surgeon General

PAO
public affairs officer

PCS
permanent change of station

PERSCOM
U.S. Total Army Personnel Command

PMOS
primary military occupational specialty

PMP
preventive medicine physician

PMS
Preventive Medicine Service

POC
point of contact

PS
prior service

PSC
Personnel Service Center/Company

RA
Regular Army

RAPIDS
Real-time Personnel Identification System

RC
Reserve Component

REFRAD
released from active duty

ROTC
Reserve Officer Training Corps

RTU
reinforcement training unit

SIDPERS
Standard Installation/Division Personnel System

SJA
staff judge advocate

SOP
standing operating procedures

SPF
SIDPERS personnel file

SQI
skill qualification identifier

SSN
social security number

STD
sexually transmitted disease

TACCS
Tactical Army Combat Services Support Computer System

TAMC
Tripler Army Medical Center

TDA
table of distribution and allowances

TDY
temporary duty

TOE
table of organization and equipment

TPU
troop program unit

TRADOC
Training and Doctrine Command

TSG
The Surgeon General

TTAD
temporary tours of active duty

UCMJ
Uniform Code of Military Justice

USAHDS
U.S. Army HIV Database System

USAMEDCOM
U.S. Army Medical Command

USAMRDC
U.S. Army Medical Research and Development Command

USAMRMC
U.S. Army Medical Research and Materiel Command

USAR
U.S. Army Reserve

USARC
U.S. Army Reserve Command

USAREC
U.S. Army Recruiting Command

USDB
United States Disciplinary Barracks

USMA
U.S. Military Academy

USMEPCOM
U.S. Military Enlistment Processing Command

Section II
Terms

Biennial
Every two years.

Extended active duty
Any period of active duty performed by a member of the Reserve Component exceeding 30 continuous days.

Health care beneficiary
A person who because of military status, employment, or by legal relationship to a person so entitled is eligible to receive medical care in military medical treatment facilities.

HIV-infected
An individual who has been confirmed to be infected with HIV by a positive ELISA test and at least two separate HIV antibody positive blood specimens tested by Western Blot or other approved confirmatory test.

HIV negative
A blood specimen that was not ELISA reactive or, if ELISA reactive, has not been determined to have HIV antibodies after confirmatory testing.

Immunological deficiency
Persistent reduction in the level of T-helper lymphocytes below 300 cells per cubic millimeter for greater than one month without other demonstrable cause;reduced or absent delayed hypersensitivity, as measured by the standardized battery of skin tests (in association with other significant clinical findings); development of thrush; increased susceptibility to either common or uncommon infections; and more severe episodes of infection than usually seen with a given organism.

Initial test cycle
A series of tests which includes an ELISA test as a minimum. If an ELISA test result is positive, the test cycle includes a Western Blot and/or any other state-of-the-art confirmatory test necessary to make a determination as to an individual's HIV antibody status.

Longitudinal
A study conducted from initial diagnosis through termination of the condition.

Major installation
Any installation with a military population of 5000 or more.

Overseas
Outside the 50 states of the United States, the District of Columbia, and Puerto Rico.

Progressive illness
Development of neurological manifestations; Kaposi's sarcoma; other lymphoreticular malignancies; thrombocytopenia; diffuse, persistent lymphadenopathy; or unexplained weight loss, diarrhea, anorexia, fever, malaise, or fatigue.

Unit commander
Company, troop, battery, or detachment commander.

Section III
Special Abbreviations and Terms
This section contains no entries.

Index

This index is organized alphabetically by topic and by subtopic within a topic. Topics and subtopics are identified by paragraph number.

PREVENTIVE MEDICINE COUNSELING RECORD

For use of this form, see AR 600-110; the proponent agency is OTSG

DATA REQUIRED BY THE PRIVACY ACT OF 1974

Authority:	5 USC 301, 10 USC 3012(G).
Principal Purpose:	To record preventive medicine counseling of Service members testing positive for exposure to HIV.
Routine Uses:	Prerequisite counseling under AR 600-110; paragraph 2-16.
Disclosure:	Disclosure is voluntary. However, failure to provide the information may result in incorrect identification.

INSTRUCTIONS

The counselor will obtain and record the administrative information required in Part I from official military records or from the patient's identification card. If the patient is not active duty military, the sponsor's information will also be included. Each item in Part II will be individually explained to the patient by the counselor. Certifying signatures of the counselor and patient will be affixed as indicated in Part II. The patient will receive one copy, the counselor will retain one copy, and if the patient is a soldier, the patient's commander will receive the original. The commander's copy will be forwarded in a sealed envelope addressed personally to the commander and marked *"To be Opened by Addressee Only."* The counselor's copy will be retained by the preventive medicine physician until the patient is transferred or for a period of three (3) years.

PART I - PATIENT INFORMATION

A. NAME OF PATIENT	B. SSN	C. GRADE	D. NAME OF SPONSOR

E. UNIT	F. LOCATION

G. DATE OF DIAGNOSIS	H. DATE AND TIME OF COUNSELING	I. LOCATION OF COUNSELING

J. Counselor:

1. NAME	2. GRADE/CORPS	4. , UNIT

3. TITLE

PART II - PATIENT COUNSELING ACKNOWLEDGEMENT

I have been informed of my initial or confirmed positive laboratory test result for the HIV antibody. I understand that I have a responsibility to prevent transmission of the infection to others with whom I may have contact, specifically--

A. My positive HIV antibody test with Western Blot confirmation means that I have been infected with HIV. Current medical knowledge indicates that once a person has been infected, it is assumed that he or she continues to harbor the virus. This means that I am infectious, or capable of transmitting the virus through my behaviors involving or potentially involving exchange of body fluids.

B. It has been explained to me that HIV infection is primarily transmitted through three routes: intimate sexual exposure; perinatal exposure *(from infected mothers to their infants)*; and parenteral exposure *(transfusion of contaminated blood or blood products, or sharing of needles by intravenous drug abusers)*. Since the virus has been isolated from various body fluids, to include blood, semen, saliva, tears, and breastmilk, personal items such as toothbrushes, razors, and other personal implements, which could become contaminated with blood or other fluids, should not be shared with others, even though the risk appears low. I have been informed that casual contacts such as hugging, shaking hands, or other common non-sexual personal contacts pose a negligible risk of transmission.

C. I have been informed that the percentage of those infected with HIV who will progress to clinical illness or suffer impaired immunity is unknown. However, estimates range from 30 to 100 percent over a long period of time. For this reason, I as an HIV-infected person, must have medical evaluations semiannually. If I am now asymptomatic and then develop unexplained fever, weight loss, or infections, I must seek immediate medical attention.

D. While homosexual and bisexual males and intravenous drug users are the majority of HIV-infected persons or AIDS patients identified so far, I have been informed that the infection can also be transmitted heterosexually. There is clear evidence for transmission from male-to-female and female-to-male. Since I can infect others, I must limit the number of sexual partners I have to minimize the possibility of transmission. Prostitutes, male or female, represent a high risk group since they have many sexual contacts and frequently are also intravenous drug abusers. I acknowledge that HIV-infected individuals as well as uninfected persons should refrain from sexual relations with members of these groups to avoid the possibility of transmission.

E. Although I may have no symptoms presently, I may still transmit the infection to others through sexual intercourse, sharing of needles, donated blood or blood products, and possibly through exposure of others to saliva through oral-genital contact or intimate kissing. I have been informed that transmission of HIV infection through sexual intercourse can be avoided only through abstinence. If I cannot abstain, then I must engage only in protected sexual relations *(i.e., using a condom)*. Males must always use a condom, and females must insist that their partners use condoms. While the ability of condoms to prevent transmission of infection is unproven, they may reduce the chance of transmissionn and I must always use them or insist on their use during all sexual encounters.

F. I have been informed that I, as an HIV-infected person, have the responsibility to always verbally inform my sexual partners of my infection prior to engaging in any intimate sexual behavior

G. I realize that I may have infected others before I knew I was infected. For that reason, I am obligated to reveal the identity of all persons with whom I have had sexual relations or shared needles so that they too can receive testing and counseling to break the chain of transmission. In addition to revealing their identities, I will personally inform all my contacts of the likelihood of their exposure to HIV as soon as possible, and recommend they seek testing and counseling.

H. I, as an HIV-infected person, will not donate blood, sperm, tissues, or organs.

I. Whenever I seek medical or dental care from any source, I must inform the provider of my HIV infection so that appropriate evaluation and precautions are taken to protect the provider and other patients. Since I am infected, I must refrain from unprotected sexual relations, and avoid pregnancy for my spouse or myself since the infection is transmitted from mother to unborn child. If I am a newborn infant's mother, I must avoid or discontinue breastfeeding.

I acknowledge that I, _____, have been counseled and understand that the preventive medicine measures listed in paragraphs A through I above, which were explained to me, are necessary to preclude transmission of HIV infections.

j. SIGNATURE OF PATIENT	DATE	k. SIGNATURE OF COUNSELOR	DATE

USAPA

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